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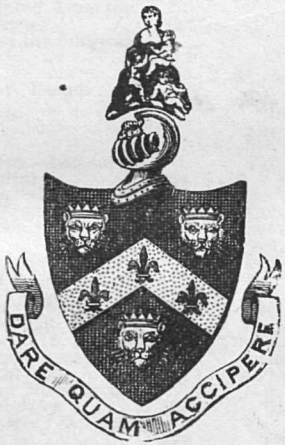

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1946

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PASSIM

CHRISTMAS whets the appetite and may satisfy it, but there is seldom any repletion; for with its passing there emerges a period of emptiness and anti-climax before the normal routine returns once more. To many even quiet contemplation of the New Year celebrations cannot wholly compensate for this. Enough of 1946 has already passed for us to forget our New Year resolutions—if not to forget them, at least to persuade ourselves that there are several adequate reasons why we should continue to smoke and not keep a diary. But Christmas is not yet too far distant for us to forget all the pleasures which accompanied it, and some of these deserve especial mention.

The singing of carols has a prominent claim at Christmas. At the Service of Carols held in the Chapel on Thursday, December 20th, the lessons were read by the Matron, the Provost of Southwark, a senior student and a member of the Hospital domestic staff. Early on Christmas morning a party of nurses and students sang carols in the wards. We hope that this traditional beginning to Christmas Day at Guy's is one that will never cease.

The Residents' Dance, in the College, was deservedly a success. Dr. and Mrs. Bishop acted as host and hostess, there was an excellent band which played, almost continuously, throughout the evening, and the College dining-room was tastefully and seasonably decorated. On Christmas Day the Residents dined in the Nurses' Home. This innovation originated during the War, but we believe that both the Residents and the Nurses would wish it to become a custom.

We congratulate the organisers of the innumerable parties which occurred with bewildering frequency at all times, in all places. A common factor was the commendable quality and large quantity of the food provided. One ward successfully combined a tea with an entertainment, without allowing the one to detract from the appeal of the other. And it was gratifying to see that shoddy products were conspicuously absent among the fine selection of toys on view before the Landon Tea Party for the children of the Borough. We offer a particular word of praise to all those who helped to make this party such a success. It is no easy matter to cope with so many children of the age of ten and under.

And so, with a happy Christmas behind us, we turn to 1946. It will take some weeks before we can write that "six" at the top of our letters without pausing to think, and perhaps some years before we fully realise the benefits which we hope this year will bring.

IT is with great pleasure that we extend to Mr. W. M. Mollison the sincere thanks of a very large number of people for his kindness in returning to Guy's for ten months when Mr. Layton was abroad. Mr. Mollison retired in 1938, and it was typical of him to offer his valuable services to the Hospital at a difficult period. His impressive and apparently changeless figure was a familiar sight during those months, and we remember him, particularly, in connection with the visit of Her Majesty the Queen and H.R.H. the Princess Elizabeth last May.

Those who were with him in the E.N.T. Department can never forget the absolute ease and great charm with which he revealed and explained, to a baffled student, the complex labyrinth of structures "above the neck."

In addition to his work at Guy's, Mr. Mollison undertook similar duties at the London Hospital—a further example of his tireless energy.

We said good-bye to him once again with gratitude and regret.

DR. S. J. DE NAVASQUEZ left Guy's in January, 1943. He served in North Africa, Italy and Germany and, during this time, made several welcome reappearances here while on leave. We are now glad to have him back with us again.

WE congratulate Dr. Alfred Alexander, late Registrar and Chief Clinical Assistant in Mr. Layton's E.N.T. Clinic, on being elected a Fellow of the American College of Surgeons.

AND we welcome back Mr. T. A. B. Harris, who was on active service throughout the war, and has now returned to resume his duties at Guy's.

THERE were two rugger dinners of considerable interest following the matches (reported in this issue) with Paris University and the South African Touring Side during the week preceding Christmas. The Paris University team were entertained to dinner in the College dining-room and the South African side at Brown's Hotel, Great Dover Street. On the first occasion the Guy's captain delivered a speech in excellent French and each member of the Guy's team received a miniature pin bearing the colours and emblem of the Paris Univeristy Club. We undertsand that the singing of the Frenchmen added a happy *coup de théatre* to the proceedings. Following the dinner at Brown's Hotel some of the South Africans attended the Residents' Dance and spent the night at Guy's. Mr. Doherty, Mr. Eckhoff and Dr. Bishop were present at both dinners, which were true to the tradition of pre-war occasions.

Menstruation

A Lecture delivered at Guy's Hospital on December 31st, 1945, by

FRANK COOK, F.R.C.S., F.R.C.O.G.

GENTLEMEN,—It is advisable to retain for the time being a liberal and non-committal definition of the menstrual process in women. The female system, and in particular that of the human female, does not readily lend itself to that degree of understanding which experts habitually accord to the mechanism of an internal combustion engine, nor does it invariably adapt itself to the precise adjustments they have become accustomed to apply thereto in the event of aberration. To introduce the current explanations of an incompletely understood phenomenon into the definition of that phenomenon can only tend to retard further progress and may well lead to therapeutic disappointment. Bartelmez states on broad lines that "menstruation is a bloody discharge associated with necrosis of the uterine mucosa, recurring, in the absence of pregnancy, at intervals of $3\frac{1}{2}$ to 5 weeks in certain primates." This definition is certainly non-committal; as such it will probably withstand the test of time. Although there is good reason to believe that menstruation is dominated by hormonal and vascular factors, we are not justified in assuming that it is free from nervous control. The influence of psychological factors is instanced by the amenorrhœa which may result from hypnotic suggestion or from the fear of pregnancy. General disturbances, such as mental shocks or bodily injuries, may initiate uterine hæmorrhage; on the other hand, many cases of functional menorrhagia are accompanied by nervous manifestations which are not necessarily secondary. Changes of environment or occupation occasionally lead to long periods of amenorrhœa which are not readily amenable to endocrine therapy. It has been suggested that a centre in the mid-brain may play a part in the control of menstruation and that this centre may be affected by a variety of external stimuli. The endocrine and visceral nervous systems possibly represent a common dynamic unit.

With these reservations we will now briefly consider the provisional hypothesis currently accepted as a working basis in order to co-relate the events that occur during a menstrual cycle of the normal or ovulatory type. After menstruation the uterine endometrium is gradually regenerated under the influence of the œstrogens. This is the proliferative stage; it corresponds to the follicular phase in the ovary, during which the Graafian follicle matures and secretes œstrogens. In due course the mature follicle ruptures and discharges its ovum under the stimulus of an additional secretion from the anterior pituitary. Ovulation is immediately followed by the formation of a corpus luteum, which secretes progesterone and, possibly, further œstrogens. Under the influence of progesterone the endometrium already proliferated

is transformed into the secretory or progestational stage, whereby it is prepared to receive the fertilised ovum. This is the luteal phase of the cycle. Whenever fertilisasation of the ovum fails, the corpus luteum begins to degenerate about fourteen days after ovulation; the onset of its degeneration is accompanied by a breakdown and shedding of the endometrium manifest as the menstrual flow.

I will not inflict upon you an account of the histological changes occurring in the endometrium during a normal menstrual cycle. Of these you are, or should be, well aware. On the other hand, the centre of interest in this connection has tended to deflect from the endometrium *per se* to phenomena essentially vascular. The actual determining *cause* of menstrual bleeding is difficult to explain. The onset of the menstrual flow approximately synchonises with the onset of degeneration of the corpus luteum in the absence of fertilisation of the ovum; but there is no proof that the mechanism is specific, although the administration of progesterone may inhibit the onset of menstruation in normal females. Further reference will be made to the œstrogen withdrawal factor as a cause of menstrual bleeding or, at all events, of uterine hæmorrhage under certain circumstances. It has long been recognised that uterine hæmorrhage occurs shortly after removal of the ovaries; this hæmorrhage may be prevented by the administration of œstrogens. Hæmorrhage also occurs after the cessation of a course of œstrogen therapy in women who have undergone a natural or artificial menopause. It is possible that the onset of menstruation is directly determined by the anterior pituitary gland, as is ovulation; a specific "bleeding factor" secreted by the anterior pituitary has been postulated, though without any definite evidence. With regard to the nature of menstruation it must not be supposed that the corpus luteum or nidation theory is absolutely proven. It depends upon the essential similarity between the premenstrual endometrium and the early decidua of pregnancy, both of which are apparently elaborated under the luteal influence, and upon the fact that menstruation almost invariably follows the surgical removal of the corpus luteum during the pre-menstrual phase. But it tends to postulate the occurrence of ovulation in every cycle, whereas it is now recognised that non-ovular cycles may simulate to all outward appearance the more normal course of events.

In non-ovular cycles (pseudo-menstruation) the endometrium undergoes hyperplasia of characteristic histological features under the unantagonised influence of œstrogens; luteal control and the consequent progestational changes are lacking. In these circumstances, uterine hæmorrhage, periodic or otherwise, is presumably of the œstrogen-withdrawal type. This mechanism has been adduced to explain various types of menstrual derangement in women—*e.g.*, functional menorrhagia or metropathia hæmorrhagica—and in this connection it will subsequently be considered in further detail. Indeed, there is very considerable evidence to support the view that many cases of menorrhagia represent non-ovular cycles and that they are dependent upon defective ovulation or the absence thereof. The current danger, however, lies in the assumption that all these cases have a common ætiology since they have some clinical similarity; there is little doubt that a too ready acceptance of this concept has been responsible for many apparent failures in endocrine therapy. Until a definite index of ovulation is available the incidence and relative frequency of non-ovular cycles in women will remain in comparative doubt and the treatment of associated menstrual aberrations will remain to some extent empirical.

PUBERTY.

The first menstrual period does not necessarily coincide with the other phenomena of puberty; sex consciousness and secondary sexual characteristics are commonly observed in young girls long before menstruation is evident, as are the maturation of follicles in the ovaries and the production of œstrogens. On the other hand, the infantile uterus is known to be responsive to the œstrogenic stimulus as is evidenced in cases of precocious puberty and menstruation due to granulosa-celled tumours of the ovary. The usual sequence of ovarian events in the female approaching full sexual development would appear to be :—(1) Incomplete maturation of follicles; (2) complete or almost complete maturation without ovulation. This stage may be accompanied by periodic bleeding of a non-ovular type; (3) full maturation, with ovulation and consequent luteinisation, associated with normal or ovular menstrual cycles.

There are considerable variations in the sequence of events in different individuals. Pregnancy may occur before puberty is manifest; many cases have been recorded. On the other hand, non-ovular cycles have frequently been observed (by means of endometrial biopsy, etc.) in girls who appeared to be menstruating regularly and

normally. This type of menstruation may be accompanied by excessive losses described as puberty bleeding or menorrhagia of puberty. The " physiological sterility" of child brides is a further indication of the absence of ovulation for a considerable time after the apparent establishment of puberty.

Delayed onset of puberty is not usually a matter of serious concern. The age of manifest puberty varies in different individuals and in different races and climates; quite healthy girls may reach the age of eighteen or twenty before they begin to menstruate. Occasionally, however, the delay may continue indefinitely, thereby constituting a condition of primary amenorrhœa.

DISORDERS OF MENSTRUATION.

It is well recognised to-day that various menstrual aberrations and abnormalities are largely due to endocrine defect or hormonal imbalance. In fact, the pendulum may have swung too far; it has been well said that the diagnosis of (hormonal) endometrial hyperplasia has become as popular and possibly as misleading as the diagnosis of endometritis in the last century. We cannot over-emphasise, therefore, the importance of excluding serious pathological lesions, such as neoplasm or gross inflammatory conditions, before we accept a glandular explanation of manifest disturbance in any given case.

AMENORRHŒA.

The complete absence of menstruation may be due to maldevelopment of the pelvic organs or to other organic abnormalities thereof; it may be symptomatic of general disease or ill-health; it may be physiological, as in pregnancy and lactation, late puberty or early menopause; it may represent a glandular imbalance or endocrine defect. It is obviously important to bear in mind the more serious ætiological possibilities. On the other hand, it is well to insist that amenorrhœa is merely a symptom; the general public and unfortunately many members of the medical profession are inclined to regard it as a cause rather than a manifestation. This tendency is well known to all practising clinicians and there is no need to dilate upon the fallacies involved. The term " oligomenorrhœa " implies infrequent menstrual periods; hypomenorrhœa refers to scanty periods. Where these clinical symptoms or absolute amenorrhœa are due to aberrations of the endocrine system, a multiplicity of factors may be in operation—ovarian, pituitary, thyroid, etc. It is not always easy to define the main or primary source, and it may be extremely difficult to remedy an essential deficiency or failure.

There are two useful classifications of amenorrhœa in practice. Cases of *primary* amenorrhœa are those in which menstruation has never occurred; cases of *secondary* amenorrhœa are those in which menstruation has ceased after having been previously established. The suppression of menstruation may be true or apparent; in some cases the menstrual process is entirely absent, in others the flow is merely retained (pseudo-amenorrhœa, cryptomenorrhœa).

Concealed menstruation or cryptomenorrhœa implies the retention of menstrual fluids in the body. It is usually due to congenital defect, the commonest cause being a failure of canalisation at the lower end of the Müllerian cords which results in a condition generally known as imperforate hymen, although this term is not strictly accurate. More rarely there is complete atresia at a higher level; occlusion of the genital canal at any point below the internal os of the cervix will lead to retention; occasionally the vagina is altogether absent. but this state of affairs is usually associated with partial or complete maldevelopment of the uterus and therefore with true amenorrhœa. When the atresia occurs at the lower end of the vagina, menses accumulate therein and grossly distend the canal—hæmatocolpos. There may be an accumulation in the uterus (hæmatometra) or in the Fallopian tubes (hæmatosalpinx). These conditions are generally amenable to surgical treatment. Very rarely the stenosis may be acquired, as a result of fibrosis following extensive inflammation, or even after unskilful operations upon the cervix. Congenital atresia may be unilateral in cases of double uterus or vagina; in this event menstruation is partly revealed and partly concealed.

True amenorrhœa, of the primary variety, may also be attributable to maldevelopment of the pelvic organs. Occasionally the uterus and vagina are entirely absent or merely represented by a nodule of fibro-muscular tissue. In a number of these cases the ovaries are apparently normal and secondary sexual characteristics well developed.

Congenital defects of the ovaries are rare; the congenital absence of both ovaries is associated, as a rule, with other abnormalities incompatible with life.

Amenorrhœa occasionally results from organic disease of the pelvic organs. It is obvious that the cessation of menstruation will follow hysterectomy or bilateral oöphorectomy, and it is well recognised that it may result from the suppression of ovarian function by means of radium or exposure to X-rays; but there are certain pathological conditions which determine amenorrhœa *per se*. Tuberculous peritonitis in infancy is said to destroy the ovarian follicular system on occasion; the uterine cavity has, though rarely, been obliterated as a sequel of tuberculous endometritis or of gonorrhœa in childhood. Bilateral malignant neoplasm of the ovaries may abolish ovarian function; in these cases the resultant amenorrhœa is a secondary symptom of trivial imporance. To produce permanent amenorrhœa it is necessary that the disease should destroy the whole of the ovarian substance; in cases of surgical removal, the retention of a mere fragment of ovarian tissue is compatible with the continuance of menstruation, as is that of a very small area of endometrium in cases of subtotal hysterectomy.

General disease or ill-health may play a part in the production of amenorrhœa, and on this account the possibility of such conditions as pulmonary tuberculosis should always be considered before endocrine therapy is instituted. At one time chlorosis was a common cause; but this disease is now rare. The menstrual function may be suppressed during or following any illness or period of mental or bodily stress. Amenorrhœa quite frequently follows a sudden change in the mode of life of young women who are apparently healthy. Girls who leave school to work in a factory or shop and others who leave home to take up a profession such as nursing often cease to menstruate for varying periods of time and without ill effect, until they have become acclimatised to their new environment. Incidentally, it is always important to remember the possible operation of psychological factors in assessing the results of endocrine therapy.

Lest I may appear to have overstressed the importance of the organic causes of amenorrhœa, let me hasten to remind you that the very large majority of cases are attributable to endocrine dysfunction. Lack of time and space prohibit my attempting to invade this territory. Let me rather refer you to Dr. Bishop and his Endocrine Clinic. His knowledge and experience are far greater than mine. May I also remind you that the endocrine clinic at Guy's was one of the first, if not the first, to be established in this or any other country.

EXCESSIVE AND IRREGULAR MENSTRUATION.

In every case of excessive or irregular menstruation the first essential of diagnosis is to exclude such pathological conditions as demand surgical or radiological treatment before any ætiological explanation based upon hormonal concepts is considered and before endocrine therapy is instituted. This applies more particularly to those cases in which there is also intermenstrual hæmorrhage to suggest the possibility of carcinoma of the cervix or of the body of the uterus, although the latter of these growths is usually of post-menopausal incidence. Whenever there is the slightest reason for doubt, a diagnostic curettage should be performed; in any case this procedure provides the material for a histological survey of the endometrium, whereby the type of menstrual cycle may be approximately established. Careful clinical examination may reveal other conditions in which, although they are non-malignant in nature, surgical measures are indicated rather than hormone therapy. Amongst these are fibromyomata of the uterus, salpingo-oöphoritis, polypi, and even abnormalities of pregnancy such as miscarriage or ectopic gestation. It is true that we cannot regard the hæmorrhage due to a threatened or incomplete abortion as excessive menstruation; but it is most relevant to note that many women refer to every unusual uterine hæmorrhage as a "period," whatever its type or source of origin. On the other hand, we have to recognise that in certain cases of metropathia hæmorrhagica, in which a prolonged loss of blood may follow upon amenorrhœa of variable duration, the clinical history is more or less the same as in that of an interrupted pregnancy. For these reasons it is always advisable in the first instance to insist upon a statement in plain English of the relative amount, times of onset and extent of uterine hæmorrhages, without prejudice as to their nature. Moreover, such terms as menostaxis, epimenorrhœa and metrorrhagia are of doubtful value, since their application varies in practice and is therefore confusing or even misleading. The term "menorrhagia" is retained as a matter of convenience, on the understanding that it applies strictly to excessive uterine bleeding of periodic character, whether the excess refer to quantity or loss of prolongation of flow.

In turning to those varieties of excessive menstrual loss that are essentially due

to endocrine imbalance, we meet a further difficulty in terminology. The terms "functional menorrhagia" and "functional uterine hæmorrhage" are certainly convenient; indeed, they have become generally adopted as a matter of common usage; but they still tend to suggest a hysterical factor or even an element of malingering. This is unfortunate, since the menstrual excess is often all too genuine, and the possibility of nervous control is at least doubtful.

It must be admitted that the effective treatment of these conditions by means of endocrine therapy has fallen somewhat short of expectations up to date, although successful results have been many and brilliant. For this comparative failure there are various possible reasons. It may be that insufficient dosages have been applied, or that the available therapeutic preparations have lacked adequate potency. On the other hand, the clinical potentialities of the more recent preparations have not as yet been fully explored—*e.g.*, the beneficial effects, limitations and possible dangers of Testosterone, and those of the follicle-stimulating hormone which determines ovulation and consequent corpus luteum formation within the ovary. It is not unreasonable to hope that the production of a natural luteal stimulus may succeed in cases where replacement therapy has failed. Other disappointing results may have been attributable to the tendency to assume an essential similarity between different varieties of functional menorrhagia. As a working basis there has been an inclination to associate this condition with non-ovular cycles; in many instances this is undoubtedly a true conception; but we are certainly not justified in postulating a mere difference of degree between all types, from the extreme developments of metropathia hæmorrhagica to those cases of functional uterine hæmorrhage which are unaccompanied by any obvious anatomical or histological changes.

For clinical and practical purposes, excessive menstruation has been roughly grouped in accordance with the age of the patient; thus we recognise menorrhagia of puberty, of maturity, or of the impending menopause. This classification has little or no strictly scientific value, but it often facilitates the choice of treatment. In girls and young women drastic procedures, whether surgical or radiological, are very definitely contra-indicated and endocrine therapy is worthy of persistent trial on that account; indeed, the results thereof have been comparatively satisfactory, particularly in cases of puberty bleeding. We cannot too strongly protest against the application of radium or X-ray therapy in young women; even hysterectomy is preferable, inasmuch as it imposes a far less serious physiological disablement. In older women there is no serious objection to the imposition of the menopause by means of surgical or radiological measures when this is made necessary by excessive losses leading to considerable anæmia. In multiparous women of this pre-menopausal group there may be chronic subinvolutional changes in the uterine musculature and blood vessels in addition to the hormonal factors concerned. These are most unlikely to respond to endocrine therapy.

The classical type of functional uterine hæmorrhage was first described by Schröder, who proposed the name "metropathia hæmorrhagica" to designate a clinical entity. The term is rather clumsy and possibly misleading, since it suggests that the primary fault lies in the uterus itself. Nevertheless, it has become accepted as denoting a condition of which the various features, clinical, histological and biochemical, are well recognised; even the treatment thereof rests on a comparatively satisfactory basis. Unfortunately, the mere classification of other types of functional uterine hæmorrhage presents very considerable difficulties. It may be that the various manifestations will ultimately prove to represent a difference of degree; but we have no real justification for this assumption at the present time.

With regard to endocrine therapy in functional uterine hæmorrhage and to the detailed investigation of that very large number of patients in whom no gross pathological lesion can be found to account for the excessive loss, I shall again refer you to Dr. Bishop. This is supposed to be a clinical lecture and I have tried to stress the more clinical aspects of the problems involved. At the same time I am very fully aware of the grave shortage of clinical material in bulk from which you gentlemen have suffered and are suffering through force of present-day circumstances. Please do not expect to find fibroids, salpingo-oöphoritis, etc., in the case of every woman who complains of excessive menstrual loss, as some of the gynæcological text-books would lead you to believe. It is their job to describe and even to accentuate major pathological entities. In actual fact many cases of apparent menorrhagia or flooding resolve without any active treatment whatsoever. A few storms do not wreck a summer however bitterly, and reasonably, those who are exposed to the showers may resent the rain whilst it is falling. It is our privilege to reassure.

Famous Guy's Men

THOMAS ADDISON (1795–1860)

By M. D. WARREN

ALTHOUGH actually born in Northumberland in 1795, Dr. Thomas Addison always considered himself a Cumbrian, and his home life centred around Lanercost, where his parents lived. After a more or less normal school career, Addison went to Edinburgh University in 1812, graduating as M.D. in 1815. He then became house-surgeon to the Lock Hospital, London, after which he held a post at the General Dispensary where he studied diseases of the skin.

Addison entered Guy's Hospital in 1817 as a perpetual physician's pupil, paying a fee of £22 1s., and became a Licentiate of the Royal College of Physicians two years later. In 1824 he was appointed Assistant Physician to the Hospital, chiefly through having attracted the notice of the treasurer, Mr. Harrison. He then became lecturer on Materia Medica and in 1837 was elected Full Physician and joint lecturer on Medicine with Dr. Bright. On the latter's retirement in 1843, Addison became the sole lecturer on Medicine. He retired from the Hospital in 1860 and died shortly afterwards, being buried at Lanercost.

Addison was an impressive man of good height and well proportioned. He was often accused of being haughty, unapproachable and rude, but these peculiarities seem to have been a cloak for his underlying nervousness. All those who knew him best testified to his continual kindness—thus Golding Bird, in dedicating his book[1] on "Urinary Calculi" to Dr. Addison, speaks of the innumerable kindnesses that Dr. Addison had shown him in the past. Wilks testifies that "Addison was not deficient in kindness of heart or generosity of disposition." Of his non-medical interests there is little information but according to Lonsdale he was musical, and in politics a Tory.

His teaching was of an exceptionally high standard. His sentences were polished and grandiloquent, his sayings practical and dogmatic. The students worshipped him and feared him rather than loved him. His personal power over them was immense; and again, to quote Wilks, who was first a student and then a colleague of his: "His lectures were of a very superior order, *ex tempore*, couched in good language which amounted sometimes to real eloquence." His greatest contribution to medical teaching was the institution in 1828 of Clinical Reports by the students. Thus started the basis of the present system of clinical teaching by the holding of clerkship appointments. To his ward-clerks he again seems to have been very kind; in a footnote to one of his numerous papers in the Guy's Hospital Reports he states that "Mr. Greenwood, Mr. Walter Johnson and Mr. Howard Johnson were my clinical clerks; and better I could not have had."

In 1839 Addison and Bright started to write a text-book of medicine which they called "The Elements of Practical Medicine." Unfortunately, only the first volume was ever published and the book was never completed. The account of the diseases was based upon their own practical experience and meticulous observation both at the bed-side and in the post-mortem room. In it there is undoubtedly the first clinical and pathological description of acute appendicitis—a disease that was only thought to have been discovered in the early years of the present century.

Although Addison attributed the very greatest of importance to accurate, all-inclusive examinations of a patient, he realised full well his own limitations in such a field. In 1846 he addressed and astonished the Physical Society by reading a paper, later published in the Guy's Hospital Reports, on "The Difficulties and Fallacies attending Physical Diagnosis of Diseases of the Chest." Starting with an acknowledgment to Dr. Laennec, Addison went on to describe over forty of these fallacies, one of which deals with pleuritic pain. This quotation also shows once more the unselfish credit he passed on to his ward-clerks:—

> "24. We may be called to a case of pleurisy before a single physical sign has been developed.
>
> "In such a case it may be doubtful whether the pain arises from pleurisy, rheumatism, neuralgia or approach of shingles.
>
> "A very good example of the latter source of fallacy presented itself in the case of Sarah F., aged 18, admitted into Summer Clinical Wards. It will be found accurately described in the clinical book by my clerk Mr. Greenwood."

His contribution to chest diseases was more extensive than these fallacies. He was the first man to demonstrate that pneumonia is not an inflammation of lung parenchyma, but consists of an inflammatory exudate into the air cells. And, furthermore, he showed that the tubercles are not the sole cause of the change in phthisical lungs, but that ordinary superimposed inflammation contributes immensely to the pathological state.

But his most famous work is the original descriptions of the disease that now bears his name. This description was published in 1855 in a very short book entitled "On the Constitutional and Local Effects of Diseases of Suprarenal Capsules." His opening words are "The leading and characteristic features of the morbid state to which I would direct attention are anæmia, general languor and debility, remarkable feebleness of the heart's action, irritability of the stomach, peculiar change of skin colour, occurring in connection with a diseased condition of the suprarenal capsules."

As an introductory to this book he describes a peculiar form of anæmia which "makes its approach in so slow and insidious a manner that the patient can hardly fix a date to his earliest feeling of that languor which is so shortly to become so extreme." Since the time of its first description this anæmia has had many names, including "pernicious" and "idiopathic." Since, nowadays, it is no longer either pernicious or idiopathic, it would surely be best to call it "Addison's anæmia."

At the time of publication of this book the medical journals took little notice of it. *The Lancet* did not grasp that Addison was describing two conditions in the one book and, consequently, wrote a rather futile review. However, the *Medical Gazette* printed a very good review and, incidentally, was the only medical journal to print an obituary.

Finally, there is one more quotation from one of Dr. Addison's papers that, probably better than anything ever written about him, sums up his character as well as explaining the unfortunate impression he left with some people. He says: "Nevertheless, my conscience tells me that, in the present instance, plain speaking, if not the most prudent, is certainly the most honest policy."

ACKNOWLEDGMENTS.

Wilks and Bettany. "Biographical History of Guy's Hospital," 1892.

Sir William Hale-White. Guy's Hospital Reports. 1926.

Thomas Addison. Guy's Hospital Reports. (Numerous years.)

Correspondence

TO GUY'S MEN AND WOMEN AT ORPINGTON.

To the Editor of the GAZETTE.

SIR,—I should be grateful for space in the *Gazette* to send a message to the many Guy's men and women who have worked at Orpington during the War. After more than six years as medical superintendent, I cannot leave without expressing my thanks to all who have helped in building up a great hospital; to Professor Johnston and Dr. Hampson and the Sector Matron for much administrative help; to my colleagues from Guy's, not only for the work they have done, but for the way in which they have done it; to more than seventy medical officers and house-officers who have worked here for six months or more before joining the Services, and are now scattered in many parts of the world; to Miss Marriott, the Matron; to the fifty Guy's and C.N.R. sisters; to more than a thousand Guy's and C.N.R. nurses who have worked here; and last, but not least, to Mr. Dowers and the K.C.C. staff and to my friends among the K.C.C. officials from Maidstone, who have, I think, almost grown to like my persistent worrying of them; and to many friends of the hospital in Orpington and the neighbourhood.

During these six years we have had more than 25,000 E.M.S. patients, including over two thousand soldiers. I need not say more because I hope subsequent numbers of the *Gazette* will tell something of the story. I am sure the success of the hospital in the hands of Dr. Scott and Miss Marriott will continue as long as the E,M.S. continues to call for its service. Whether the traditions that have been built up can serve

for a still longer period probably depends on the Government plans for the future hospital services.

Once again I thank you all.

I am, etc.,

MAURICE CAMPBELL.

December 31st, 1945.

ORPINGTON RE-UNION DINNER.

To the Editor of the GAZETTE.

SIR,—Almost six years of War have brought a large number of medical and house-officers—about seventy—to Orpington County Hospital. During all this time and, despite the large number, the greatest unity and team spirit has existed and this produced one of the happiest and most hard-working communities in which it has ever been my privilege to work.

I have now left but, on a recent visit to the hospital, Dr. Campbell suggested that it would be very pleasant to try to get in touch with as many men as possible with a view to a re-union dinner at some later date when more may be available than at the moment. May we take up space in the *Gazette* to ask all those who have been at Orpington to write to me at the above address and to let me know their whereabouts as soon as they return to England. I will do my best to keep in touch with them and give good notice of any plans for the proposed dinner.

I am, etc.,

R. A. JOHNSON,
Ex Medical Officer.

217, Ashby Road, Scunthorpe, Lincs.

STUDENTS' UNION.

To the Editor of the GAZETTE.

SIR,—In his letter in your issue of December 8th, 1945, concerning the proposed re-organisation of the Clubs' Union, Mr. Eckhoff says that "expressions of opinion from students, either singly or collectively, would be welcomed."

May I, then, briefly touch on one aspect of this matter—namely, the suggested absorption of the Students' Union? As Students' Union secretary for the past six months or so I have had the opportunity to see a good deal of the sort of work that is done by representatives elected from the various years, and, as a result, am convinced that much of it would not be so well or so suitably carried out by the larger body proposed.

Mr. Eckhoff mentions that the Students' Union was formed to provide facilities for cultural and other recreations of a non-athletic type. Its primary object, however, is "to represent the opinion of students both within the Hospital and without"; and a large part of its work has been concerned with doing so in a dozen different ways. This includes such matters as the maintaining of friendly relations with students of other hospitals, the investigation of student complaints and suggestions of any and every kind, and relations with the British Medical Students' Association; none of which would seem to be suitable for discussion by a large and formal committee that includes staff members.

The Students' Union is also in a good position to sponsor and regulate new ventures of a kind that a more formal body is not immediately prepared to recognise.

Apart from this, it seems to me that a purely student body plays a positive and useful part in the life of the Hospital by giving to as many students as possible a feeling of confidence and self-respect in the managing of their own affairs and a first taste of administrative responsibility.

I do not see that this need clash with the larger-scale activities of the Clubs' Union Council, where large sums of money are handled and where the continuity afforded by staff members is, I agree, essential.

I am, etc.,

T. B. BREWIN.

Guy's Hospital, S.E.1.

RESIDENTS' BALL.

To the Editor of the GAZETTE.

SIR,—We have great pleasure in announcing that the Residents' Ball will be held on Friday, March 8th, 1946, at the Dorchester Hotel, W.1, from 9 p.m. until 2 a.m. For those who were not at Guy's before the War, we would explain that this was an annual function usually following close upon the Residents' Play. Unfortunately, the Residents' Play, in its old form, is still in abeyance this year, but the Residents' unanimously decided that the Ball should take place if possible.

Accordingly, a committee has been formed as follows :—Dr. A. H. Douthwaite, Mr. H. J. B. Atkins, Mr. A. Bulleid, Mr. A. Batty Shaw (President of the Residents), Mr. J. D. L. Reinhold (Vice-President), Mr. J. E. Attale and Mr. K. D. Allanby (joint secretaries).

Double tickets, two guineas each, may be obtained from any member of the committee ; whilst written applications should be addressed to the secretaries. Cheques should be made payable to Guy's Hospital Residents' Ball.

We regret that, owing to the difficult conditions still prevailing, supper cannot be served, but a light buffet is included in the price of each ticket and a licensed bar will be open throughout the evening.

May we express the hope that all Guy's men, past and present, who possibly can, will come and join us in making this a special occasion and re-union after eight years ?

It would greatly assist us if applications for tickets are made as early as possible, to avoid disappointment.

We are, etc.,

J. E. ATTALE,

K. D. ALLANBY,

Secretaries, Residents' Ball Committee.

Guy's Hospital, S.E.1.

Dobson and Young

AT 5 p.m. on December 17th, 1945, every seat in the Physiology Theatre was taken, standing room was difficult to find, and even the gallery was filled to capacity. This was not unexpected in view of the reputation that Dobson and Young have gained for themselves, both with the Forces (to whom they have lectured since the beginning of the war), and—since their first broadcast—with the whole country. For the benefit of the uninitiated, however, it may be said that their talks are concerned with the appreciation of music, and that their remarkable popularity is due to the highly colourful and attractive way in which they present so much good sense on the subject.

Until their visit to Guy's those of us who had enjoyed their broadcasts did not know how much we were missing. On seeing Mr. Dobson in the flesh we appreciated more than ever before the many sides of his personality, his wit, and his warm enthusiasm ; above all, the easy way in which he continually slides from serious argument and illustration of good music into amusing satire and mimicry of the bard. On seeing Mr. Young, we could only marvel at the efficiency with which he operates his gramophone. Quietly and without fuss, his records are blended in with the remarks of his partner in a way that seems almost telepathic.

It goes without saying that the visit was an unqualified success. For no less than one hour and twenty minutes there was not a dull moment nor a word missed. Grateful thanks are due to Messrs. Dobson and Young for treating their audience to such a stimulating and delightful talk.

T. R. B.

Sport

Rugby

GUY'S *v.* PARIS UNIVERSITY.

(*At H.O.P., Wednesday, December 19th*, 1945.)

Result: Guy's, nil; Paris University, 3 points.

To Guy's fell the honour of entertaining the first French club side to visit this country since the English Rugby Union broke with the French Federation in 1931. This was in keeping with Guy's Rugby traditions, as it will be remembered by many old Guy's men that Guy's, for many years, paid frequent visits to France to play their most outstanding clubs. Moreover, had the war not intervened, Guy's would have been the first English club to play in France, following the break, as they were due to play Stade Francais Metropolitaine in Paris in the middle of September, 1939. It was indeed a great occasion for Guy's to stage this match, and the club officials, together with the Press, did everything to make it a success.

In meeting Paris University Guy's were opposed to an unknown quantity. To be defeated by a try to nil by the Frenchmen was nothing to be ashamed of as the game was played at a remarkable pace, and some really delightful rugger was the result. Paris University taught us much and especially noticeable was the manner in which their players turned defence into attack by kicking to touch on the turn. They had an outstanding stand-off half in H. A. F. Jorge, who constantly ploughed his way through the centre to open up the game for his backs. His touch-kicking was also first-class, as was that of the full-back, M. J. C. Hausséguy, normally a forward.

Another outstanding feature of the game was the number of occasions that the Frenchmen called for a "mark." This subtle manœuvre enabled them to extricate themselves from the result of many awkward kicks across field by our backs, and punts ahead by our fast following-up forwards.

Paris had an excellent hooker in M. A. D. Gazaux, but their scrum-half found much difficulty in getting the ball away owing to the close attentions of A. A. Bailey at scrum-half for Guy's, who played extremely well. Van der Westhuizen was given few chances to break through owing to the tenacious tackling of M. J. R. Alzaté, and, as a result, the ball seldom came out for our wing three-quarters to show their worth in attack, but it can be said of N. K. Macrae-Gibson and D. Le Clus that their defensive play was largely responsible for preventing the Frenchmen from crossing our line more than once.

The only try of the match came early in the second half, when H. A. F. Jorge and Paul Despessailles broke away and gave H. M. Placé, on the right wing, a try in the corner.

The conditions were against three-quarter play owing to a drizzling rain and a greasy ball, but players on both sides may be congratulated on handling the ball with an accuracy which, throughout the game, made it most entertaining to watch, and only some first-class tacking prevented either side gaining an advantage.

GUY'S *v.* SOUTH AFRICAN SERVICES.

(*At H.O.P., Saturday, December 22nd*, 1945.)

Result: Guy's, 3 points; South African Services, nil.

When readers of the *Gazette* scattered in various parts of the world read that Guy's met a Rugby XV from South Africa they will no doubt conjure up memories of that amazing team which represented Guy's in the years immediately following the war of 1914–18 under the captaincy of W. D. Doherty. Guy's has always been considered the second home of South Africans studying medicine and dentistry in this country, and there is no doubt that this match did much to strengthen the bonds existing with that Dominion. To add to the friendly atmosphere Guy's had five South Africans in their side, and it was one of them, D. Le Clus, who kicked the all-important penalty goal by which Guy's won the match, thus succeeding where St. Mary's failed.

T. L. T. Lewis and M. Hatton were absent, playing conspicuously for London against the Kiwis at the White City; otherwise Guy's were at full strength.

Not for many a long day has the Guy's team-work shown to such advantage. The tackling, backing-up, falling on the ball, and even the line-outs surpassed anything hitherto produced. It will take an exceptionally good side to score against Guy's if we can only reproduce this grand team spirit. There is an abundance of skill in attack, but all through the season this has been wasted owing to lapses in defence.

The South Africans had more of the play territorially and time after time they would swing the ball along the line, seemingly anxious to get it out to the wings; but here their movements finished owing to brilliant tackling by N. K. Macrae-Gibson and D. Le Clus. Our players broke up all the South African passing movements by tackling the man with the ball promptly and solidly, and especially prominent was P. J. Dwyer at stand-off half in place of F. Le Clus.

Guy's had many narrow escapes and in their anxiety gave away several penalties by getting off-side, but O. Swanson, usually the safest of place kicks, failed with them all. The South Africans, too, were penalised for being off-side on many occasions. The pressure on the Guy's line during the last fifteen minutes was so fierce that our supporters yelled themselves hoarse to inspire our players, and right well they responded.

It was good to see the Guy's forwards packing together in a solid mass in getting the ball away from their own goal line, and in the loose rushes every man seemed to use every ounce of energy.

There is not much to say about the Guy's attacking movements as the backs had few chances to handle, but when they did it was noticeable that the line worked smoothly and, in contrast to the South Africans, they endeavoured to make progress by varying their play with an attempt at a "dummy," a side-step or a kick across field.

Interest in Guy's rugger is increasing and it must have been gratifying to the players that more members of the staff were present at this game, and the one against Paris University, than at any previous game this season. Their presence is always an inspiration to the players.

Association

GUY'S *v.* CAMBRIDGE UNIVERSITY.

(*Played at Cambridge, on November 1st*, 1945.)

Result: Lost 6–1.

Guy's visited Cambridge with the hope of avenging the defeat which was suffered last

year. Although our wish was not fulfilled, we nevertheless had a very enjoyable game.

After a somewhat shaky start Guy's settled down well and tried several times to pierce the strong Cambridge defence. Play passed quickly from one end of the field to the other, both goals having many narrow escapes. After thirty minutes' play in the first half the Cambridge outside-left scored with a fine shot from a very oblique angle. This left wing was a perpetual worry to the Guy's defence. We were perhaps fortunate that this man did not shoot at goal more often. After this goal play settled in midfield until half-time.

After the interval Guy's pressed hard and were rewarded within ten minutes. Trist bustled his way past two Cambridge defenders and hooked the ball into the net from a very difficult position. Cambridge tried hard to regain the lead and were successful a few minutes later. After this the Guy's players seemed to tire slightly and, although determined in their efforts, were unable to prevent the Cambridge attack from being successful on four other occasions.

Team.—I. L. Busbridge; E. M. Newton, R. A. C. Dove; M. J. L. Sykes (captain), H. R. C. Riches, C. S. Matthews; I. A. H. Munro, R. K. Foster, A. E. Trist, W. A. Evans, R. Owen.

Hospital Information, etc.

Notice

YORK CLINIC

HOUSE OFFICER.

Applications are invited for the position of House Officer in the York Clinic for Psychological Medicine in Guy's Hospital.

If the post is filled by a B.2 House Officer it will carry a salary at the rate of £200 per annum, with provision of board and lodging or an allowance at the rate of £100 per annum in lieu. The post would normally be held for a period of six months. Special consideration will be given to Medical Officers leaving the Services and desirous of obtaining further experience in this branch of medicine, and who may or may not be in receipt of a Post Services Training Grant.

Applications in writing, with the names of two referees, should be submitted to:—

The Secretary of the York Clinic,
Counting House,
Guy's Hospital, London, S.E1.

Applications should reach the Secretary not later than January 20th, 1946.

Pass List

UNIVERSITY OF OXFORD.

Pharmacology and Principles of Therapeutics. June, 1945.

R. A. Bruce — D. C. Turk
R. E. Hansen — D. P. Winstanley

The Services

AWARDS.

Awards in recognition of o; gallant and distinguished services in Italy:—

C.B.E. (Military Division).

Brigadier (Local) E. R. Boland, O.B.E., R.A.M.C.

M.B.E. (Military Division).

Major (Temp.) P. W. Clarkson, R.A.M.C.
Major (Temp.) A. F. W. Hall, R.A.M.C.

Mentioned in dispatches in recognition of gallant and distinguished services in Italy:—

Lt.-Col. (Temp.) H. J. B. Atkins, R.A.M.C.
Lt.-Col. (Temp.) W. E. Lloyd, M.C., R.A.M.C.
Major (Temp.) R. W. Cope, R.A.M.C.
Major (Temp.) R. H. Croot, R.A.M.C.
Major (Temp.) J. Howell, R.A.M.C.
Major (Temp.) K. R. D. Porter, R.A.M.C.
Lieut. E. A. Williams, R.A.M.C.

Mentioned in Dispatches.

Temp. Actg. Surg.-Lieut. Cmdr. K. J. G. Way, R.N.V.R.

Appointments

Stoneham, F. J. Russell, L.R.C.P., M.R.C.S., D.A. (R.C.P. & S.), Senior Anæsthetist, Birmingham Accident Hospital and Rehabilitation Centre, Bath Row, Birmingham, 15.

Change of Address

Berkley, E. A. R., Lt.-Col., R.A.M.C., No.5 (Brit.) Convalescent Depot, B.A.O.R.

Stevens, John, L.D.S., R.C.S., 14, High Path, Wellington, Somerset.

Webb, R., Surg.-Lt., R.N.V.R., Royal Naval Auxiliary Hospital, Idsworth House, Horndean, Hants.

Zorab, Edward C., M.B., B.S., 20, Brunswick Place, Southampton. (Tel.: 3368.)

Papers by Guy's Men

Bookless, A. S., and Another. Typhoid fever complicated by benign tertian malaria. *Brit. Med. J.*, 1945, ii, 804.

Kenton, Bernard. Direct laryngoscopy and tracheal inturbation. *Lancet*, 1945, ii, 742.

Reading, Philip. Ligature of anterior ethmoidal artery for arrest of profuse epistaxis, *Brit. Med. J.*, 1945, ii, 848.

Nelson-Jones, A. Aseptic necrosis at sites of continuous intramuscular penicillin infusions. *Lancet*, 1945, ii, 817.

Carpenter, E. Brodie. Second thoughts on soil fertility and dental caries. *Med. Pr.*, 1945, 214, 414.

Pringle, K. E. Eruption of lower second premolar in spite of retained second deciduous molar. *Brit. Dent. J.*, 1945, 79, 344.

Holms, Selwyn, and Another. Report from a maxillo-facial centre at a Royal Air Force Casualty Clearing Station in England. *Ibid.*, 346.

Deaths

SIMPSON-SMITH, Alex.—T/Lt. Col. R.A.M.C., previously reported missing after the fall of Tobruk in June, 1942, but known to have escaped once after all casualties had been dealt with; now reported buried in the Halfaya-Sollum War Cemetary.

HOWARD.—On December 27th, 1945, John Alexander Howard, M.D., at 5, Beulah Hill, Upper Norwood.

Births

WIDDOWSON.—At King's College Hospital (Private Patients' Wing) to Brenda ("Betty"), wife of Surg.-Lt. Cmdr. (D.) E. V. B. Widdowson, R.N.V.R.—a son (Nigel Desmond).

EDS. {J.M.H. R.H.N.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

THE advantages, to the student, of living in or near the Hospital are too numerous and too obvious to be enumerated. Such advantages will be available, in the near future, to a greater number of students than was possible during the War years.

The re-opening of the College is estimated to take place towards the end of February. When in full use it is expected to accommodate twenty-five students in addition to the Residents. A separate bedroom will probably be available for each man staying there and the communal arrangements will be vastly superior to those available at present in the less salubrious cramp of the Hostel. The use of this ancient building, at once scorned and loved by its inmates, may even be discontinued when the new accommodation plans are extended into full practice.

Hand in hand with these arrangements goes the proposal to open the College dining-room for evening meals, and upon this depends the opening date of yet another source of student accommodation. The Newcomen Day Nursery, Newcomen Street, will be in use, it is hoped, by the end of this month ; there is room here for a further eighteen or twenty resident students. Obviously, however, these men cannot be accommodated until they can also be fed. The bedrooms will be shared by two to four, the number varying in accordance with room size. Even so, most of these rooms are quite large and every man will have a considerable amount of space for his own use.

May we here and now still the voice of criticism about delay in these matters by pointing out some of the many difficulties presented to those in charge of their organisation. Gross shortages of labour have made the rebuilding of the College and the conversion of the Day Nursery long and difficult tasks. When completed, the shortage of staff to run and clean the buildings presents a further problem. The difficulties of obtaining the materials with which to furnish the rooms must be clear to all. In view of these and many other similar problems, the authorities are to be congratulated that the increase and improvement in accommodation has been made possible at all—late or early.

ARRANGEMENTS are being made for the accommodation of two students for periods of a fortnight at a time at Preston Hall. This unique opportunity for the study of tuberculosis, so far as we know, has never been afforded Guy's men before. They will pay only for their lodging during the period. Further details of the plan will probably be available at a later date. We have often pressed for the institution of such teaching schemes in these pages and welcome this one as a definite advance.

INCREASES in the teaching staff made it possible, some months ago, to organise four surgical firms and so cut down the size of each. Teaching on the medical side is now to follow this example. Beginning on January 16th, 1946, there will be four medical firms under the care of Drs. Marshall, Mutch, Conybeare and Campbell.

Tropical Diseases in the United Kingdom

A Clinical Lecture delivered at Guy's Hospital by

E. R. BOLAND C.B.E., F.R.C.P.

GENTLEMEN,—Old soldiers, while physically living in London, Cheltenham, Camberley or Chelsea, have an irritating habit of living spiritually in Poona, Jubbulpore, Cairo or the Gold Coast, so that nothing can occur in this country which does not immediately and vocally remind them of some more soul-stirring or soul-satisfying event in those possibly glamorous, but always far off, days in the East —Near, Middle or Far. It may seem to you in keeping with this somewhat boring habit that I have selected Tropical Medicine in England for the title of my first clinical lecture since my return.

Army Medicine in a tropical or semi-tropical country is very stimulating to a physician because, in addition to all the normal diseases common on these shores, are added a vast range of diseases hitherto only names in a text-book. Without going further East than Suez or West than Casablanca you may see plague, typhus, kala azar, malaria, leprosy, Weil's disease, undulant fever, relapsing fever, ratbite fever, bilharzia, rabies, dengue fever, sandfly fever, beri-beri, pellagra, sprue, several kinds of dysentery, and a dozen different kinds of worms, to mention only a few of the probable and possible diseases met with amongst the thirty or forty nationalities that composed the Forces of the C.M.F. and M.E.F.; the diseases due to physical agents varied from poisoning with mustard gas and the drinking of ethylene glycol or anti-frost and from heat hyperpyrexia to frostbite and gangrene. Even the common diseases like typhoid, infective hepatitis, diphtheria, smallpox and atypical pneumonia, instead of being met with as single species as they are in this country, are met with by battalions. Differential diagnosis of an undiagnosed pyrexia becomes a bit humdrum when, instead of a choice of more than a dozen different diseases, you are reduced on coming home to the usual possibilities of infective endocarditis, miliary tuberculosis or Hodgkins' disease. So you may understand, if not forgive, attempts to hark back to some of the dramatic diseases of the immediate past when confronted with the comparatively well-worn problems in the wards or out-patients'. Perhaps one of the reasons for looking backwards is that diagnosis and treatment of tropical diseases are so much easier than in diseases of more temperate climes. It is always with trepidation that you meet tropical diseases for the first time, and it is a pleasant surprise to find that almost for the first time diseases are almost as described in the text-book; that the diagnosis, definite on clinical grounds, can usually be confirmed by specific laboratory tests, and that there is usually a treatment which is specific and effective. It is the sort of medicine you expect to meet when you enter the hospital for the first time with the bloom of fresh innocence on your minds, with all your facts, a neat black and white, based on the Reader's Digest, Black's Family Doctor or the Miracles of Medicine Series, before the grey of disillusionment clouds your mind until you emerge into the fuller clarity of qualification—if you do. Apart from a necessary elementary knowledge of the usual symptoms and diagnostic methods employed, to think of the possibility of a tropical disease is to be three-quarters of the way towards its diagnosis. This is my excuse for choosing such a subject since amongst the thousands of troops returning to England there are, of a certainty, a large number still infected with tropical diseases which must be thought of in differential diagnosis for many years to come.

The first of these is malaria, of which there have already been many hundreds of cases in soldiers returning to this country from the Far East, Africa, Italy and Sicily; it may surprise you to know that the most important single disease in the Normandy campaign was malaria—needless to say not contracted in France, but brought from Sicily and Italy by the 50th and 51st and other Divisions which came from the 8th Army to take part in the landings.

Before I left this country in 1940 I had never seen a case of malaria except for a few cases of artificially induced disease in cases of general paralysis, nor had I any more knowledge of them than might be expected of anyone who did not expect to meet them in an examination; and how very neat and precise were my ideas. There was in my mind a clear picture of the progress of malaria; first, the stage of malaise and chilly feelings, then gooseflesh and shivering followed by the rigor with chattering

teeth, pallid hue and cold extremities; then the hot stage with burning skin, headache and delirium; then the defervescence with drenching sweats, and rapid recovery for two, or was it three, days? I never could quite remember; and then the whole cycle would occur over again unless cut short by the intelligent physician with quinine, which was, I think, the only drug of which I had any clear recollection.

It was not long before this extensive knowledge was put to the test, because about ten days out from Liverpool we dropped anchor for about one night off Freetown. We lay off about half-a-mile from the shore and almost no one was allowed to land. I enquired about the danger of malaria and was told that we were too far from the shore for the mosquitoes to reach us. It is true that I advised that orders should be given for all the doors and portholes to be kept closed at night; and no one was supposed to be on deck after dark, but this was as much on account of possible French raiders from Dakar as from mosquitoes from the shore. At all events, in the sweltering tropical heat I was probably one of the few who obeyed the order, if indeed I did. Next morning we weighed anchor for the Cape. I was in general charge of the sick on the *Mauretania* and we had the usual number of cases of infectious disease—tonsillitis, et cetera, as well as a certain number of cases with pyrexia of influenzal type, of which there had been a number all the way out. It was therefore no surprise when about twelve days out from Freetown, four out of five soldiers from one cabin were admitted to the hospital on board with the diagnosis of influenza. There seemed to me nothing specially odd about them, and it was assumed that in a few days they would recover like the rest. A day or so later I was asked by the *Mauretania's* ship surgeon to see a young sailor afflicted with a most mysterious disease of which the outstanding symptoms were high pyrexia, extreme drowsiness, a severe anæmia and a large spleen. He was desperately ill and the spot diagnosis seemed to lie between miliary tuberculosis and leukæmia. While investigations were being carried out I was asked by one of my medical officers to see the four cases of influenza once more. Contrary to expectation they were not making the progress which had been anticipated. I was not able to make much of them; their temperatures had not quite settled; they still looked more ill than they had any right to be perhaps and one of them was slightly drowsy. There was nothing in their chests and, possibly with some vague idea of typhoid or paratyphoid in my mind, or possibly from some vague automatism, the result of my training at Guy's, I idly palpated the abdomen of one, more to give me time to think than with any expectation of light. To my mild surprise, the spleen was palpable. Perhaps it was this that made the first suspicions of malaria arise in my mind, or perhaps I thought of typhoid, but with only slightly raised expectation I felt the abdomen of the next one. Again I found an enlarged spleen, and now, full of expectation, I palpated the other two abdomens, but this time was disappointed. Still, once the idea of malaria had arisen in my mind in spite of the assurances given at Freetown, the diagnosis suddenly became obvious and, even before the microscopes and stains had been unpacked from the hold to confirm the diagnosis, we started treatment and recovery was immediate. Furthermore, I dashed down to the ship's hospital, and it was at once obvious that the sick sailor was dying of cerebral malaria; he, too, was saved by intravenous injections of quinine, in which he was more fortunate than several soldiers in the *Queen Mary* and the *Aquitania* who died of a mysterious disease before the convoy reached Colombo.

These were my first cases of malaria and they taught me in future always to think of malaria first in all mysterious pyrexial cases in the Tropics, a lesson which stood me in good stead numberless times later. Malaria was not very common in the parts of Egypt usually frequented by troops, but in another hospital near us there were several deaths among airmen from malignant malaria because the diagnosis was not thought of. In one case the erroneous diagnosis was cerebral hæmorrhage and, in another, heat hyperpyrexia. All the airmen had recently come out from England, but they had all come out by the West Coast of Africa and stopped at an airport called Takoradi, where they had been infected, and then flown to Egypt during the incubation period. Air travel has opened up tremendous possibilities in the spread of disease and since nowadays a man may be struggling through Central African jungles to-day and walking down the Borough High Street to-morrow or the day after, it is essential that you get a clear history of a man's recent travels since every port of call may open up a new diagnostic possibility. I may seem to have been painting a somewhat gloomy picture of the lethal possibilities of malaria, but malignant malaria of this lethal type, although met with in this country, is not likely to be frequently encountered. It is far otherwise with benign tertian malaria, which will be common for some time. Firstly, because it is a much more common infection in most coun-

tries than malignant tertian, and, secondly, because it is much more likely to relapse than malignant tertian and for a much longer period. It is important to know that relapses of malaria will eventually die out either with or without treatment. Infection with benign tertian malaria never persists for more than two years from the time of infection. Malignant tertian malaria, if more likely to shorten the patient's life, has itself a shorter life and rarely recurs after six months from the first infection. The only type of malaria which goes on relapsing for years is quartian malaria, a very much rarer infection which has been authentically reported on occasion to relapse for many years. In other words, in about two years from the return of the last soldiers from "foreign parts," malarial relapses from disease contracted outside this country will not occur. This statement, of course, like many other statements of fact, will be hotly denied by many stout "qua hais" who continue to use their "touch of the fever" as an alibi for years and years even though no one will ever find the parasites during their so-called attacks. Relapses may occur for no particular reason, but they are particularly liable to be precipitated by anything which depresses the patient's general resistance. They follow exposure to cold and often occur as a result of change from abroad to this wintry climate, or even from rising above 10,000 feet in an unheated aeroplane. They often follow wounds, surgical operations or intercurrent illnesses and I have often seen the mysterious clinical problems presented by these cases clear up after a blood smear is taken. This is not the time to go into the symptomatology of malaria which is extremely varied, but the relapses which you are most likely to see have the clinical features which I described as the limit of my knowledge in 1940. The cold stage, the rigor, the hot stage and the sweating stage will probably be seen in most of your cases and the fever will have the periodicity characteristic of the type. It is only in arrivals by air that you may see the primary cases which present difficulty in diagnosis which I have touched upon before, and it is important to remember that the inoculation period of malignant malaria after biting under natural conditions is never less than nine to ten days, while in benign tertian it is rarely less than fourteen. The inoculation period, of course, can be much longer and one frequently sees cases which develop months after the last possible exposure to infection either from natural reasons or because the patient has been taking mepacrin to suppress the disease. Also, many of the cases which appear to be primary are really relapses in which the initial infection has been missed or misdiagnosed, an easy thing in countries where short-term fevers are as common as colds in this country. Individual cases may relapse a great number of times, especially if the infection is benign tertian. A very few of these cases are cachetic or have severe secondary anæmia with a pigmented skin and an enormous spleen, but the majority appear in fairly good health and not all have a palpable spleen, although it is most often palpable in these chronic cases.

The treatment of these cases is simple or symptomatically simple. Either quinine or atebrin, whose British name is mepacrin, will cause a rapid fall in temperature or a rapid disappearance of parasites from the blood. Quinine is given in solution in doses of 10 grains three times a day for three days. Atebrin may be given instead in doses of 0.10 of a gramme three times daily and often bigger doses up to six 0.10-gramme tablets may be given daily. If quinine is given it is usually followed by atebrin for five days in doses of from three to eight tablets daily, and this drug may then be followed by tablets of 0.01 of a gramme of plasmoquin three times a day for three days. In this country benign tertian relapses have been treated by quinine gr. 10 three times a day, combined with plasmoquin 0.01 of a gramme three times a day for ten days with excellent repeated results. I could take hours discussing the permutations and combinations of these drugs, so I will content myself with saying that all are about equally effective in treating the attack, but that none are completely effective in preventing relapse.

The diagnosis of malaria primarily depends on the finding of the parasites in the blood. Between the attacks this will usually be impossible, but they should be found during the pyrexial attacks or immediately after them if therapy has not been started. They become difficult to find very soon after the initiation of the treatment. Where the parasites hide themselves when they are not in the blood is the great mystery of malarial infection and, although the reticulo-endothelial system is as usual under suspicion, the extra-erythrocytic cycle has never yet been found. The acute cases of malaria of recent origin with vomiting, drowsiness or other cerebral or severe symptoms should start their treatment with intravenous quinine or intramuscular (but not intravenous) mepacrin.

When I was a ward clerk a laugh could always be raised by the industrious book-worm, represented on most firms, who seriously gave as one of the common causes of

splenic enlargement in this country kala azar. It was in those days a disease which seemed almost mythical and as remote from human experience as Tsutsugamushi river fever or goundou or dognose still are from mine. And yet since the War many cases have reached this country and puzzled clinicians more than somewhat. It is another disease which can be diagnosed if it is thought of. I saw my first case of this disease in Egypt in 1941, I think. It was towards the end of the campaign against the Italians in Eritrea and Abyssinia when the troops were being transferred to Egypt and the Western Desert. The first information about this appeared in a directive from medical headquarters in Cairo describing a disease in which the main symptoms were pyrexia, often undulant in character, rather similar to a Pel-Ebstein temperature in Hodgkins' disease with enlarged spleen and a leucopenia. The subsidiary symptoms were a pigmented skin, scaly hair and a secondary anæmia and, it was stated, if I remember correctly, that it occurred in cases from a district called Gallabat and mostly in the Essex Regiment. As soon as I read the description I walked straight down to the typhoid ward and looked at a case which had been three weeks diagnosed as typhoid, although, apart from the leucopenia, all investigations had so far been negative. As soon as the diagnosis of kala azar was thought of, all the rather puzzling symptoms which had not quite fitted the diagnosis of typhoid, at once clicked neatly into place and, to make assurance doubly sure, he was a C.S.M. in the Essex Regiment from Gallabat. All over Egypt at the same time officers in charge of medical divisions were finding in this directive the explanation of many puzzling cases of long continued pyrexia.

I did not meet this disease again until after the close of the Sicilian campaign, when I saw one case of a soldier in Italy who had come out from home to land in Sicily and then later landed at Salerno in Italy. Almost at the same time I received information from General Biggam, the Consulting Physician at the War Office, that some cases of kala azar had developed after their return to England. I circulated a description of the disease and at once cases were reported in small numbers all over the theatre. I should have anticipated the appearance of cases because Catania in Sicily and the Italian coast south of Naples are well-known European foci of the disease. So when confronted with cases of prolonged pyrexia with enlarged spleens add kala azar as a possibility to aleukæmic leukæmia, infective endocarditis or Hodgkins' disease. Diagnosis can be made certain by finding Leishman Donovan bodies after sternal puncture or splenic puncture, or occasionally in the blood or on culture from the blood. The disease is fatal if untreated, but neostam or other preparations of antimony are successful in the vast majority of cases. The inoculation period can usually be measured in months rather than years, and this fact means that the disease will not be a problem for very long after the return of troops from infected areas. The total number of cases will not be large, but they are the type of case most likely to reach a general hospital.

A much more common disease which has already occurred in a large number of infected soldiers is amœbic dysentery and its complications—hepatitis and hepatic abscess. The disease is common in all the countries of the Mediterranean and, of course, in all eastern countries. Cases arrive in this country either because they have contracted the disease abroad and they arrive still suffering from it or develop it after they arrive, or else have a relapse following treatment and apparent cure elsewhere. The frequency with which the disease relapses probably depends on the efficiency of the treatment given. At one time a great number of cases treated in India and Egypt relapsed and the standard treatments came in for considerable criticism. In North Africa and the C.M.F. relapses were comparatively infrequent although follow-up records were far from perfect. Whether efficient treatment can prevent relapses or not, the fact remains that relapses are common. The main symptom is, of course, diarrhœa, usually intermittent, with griping pains in the lower abdomen, sometimes with tenesmus of the rectum. The stools are loose, sometimes semi-purulent, and often blood-stained. Except in acute cases, not likely to be seen in this country, there are not usually more than three or four stools in the day. In the really acute cases there may be twenty or thirty stools and often practically pure blood is passed. The patients tend to become emaciated, there is often abdominal tenderness over the cæcum, transverse colon or the sigmoid colon, which may be enlarged and papable as well as tender to the touch.

Diagnosis depends on the clinical history, the finding of entamœba histolytica in the stools and the sigmoidoscopic findings. The finding of the amœbæ in the stools needs a careful technique and experience. Most pathologists go through a period when they can never find the parasites even when the clinical and

sigmoidoscopic evidence is strong and then another stage when they find them in nearly every stool to the considerable embarrassment of the clinician and then, as a rule, they reach a stage of equilibrium when their findings can be trusted. The efforts of the pathologist to find the entamœbæ can only be successful if the clinician gets the specimen to the pathologist while it is still warm and unmixed with urine or disinfectant. It is no use examining a specimen of fæces which is not fresh. Sometimes one finds no amœbæ, but finds only amœbic cysts. The significance of these cysts is a matter of dispute. There is no doubt that many people who pass cysts have never had and never will have any clinical symptoms of the disease. For example, clinical amœbic dysentery occurs exceedingly rarely in this country, whereas cyst carriers are not very uncommon; figures as high as 5 per cent. or 10 per cent. of various groups have been reached in this country particularly amongst lunatics, if one may still use that old-fashioned term. Whether lunatics are more liable to be infected because of defective hygiene or merely because they are in a convenient group to study I do not know, although I suspect the former since epidemics of bacillary dysentery are common in asylums; also the presence of amœbic cysts must, of course, mean that there are true amœbæ present somewhere in the bowel even if their presence there is not causing any bowel damage. It is possible and even probable that for clinical symptoms to occur, not only must the parasite be present in the bowel, but also there must be some other factor which lowers the general and tissue resistance allowing them to increase and multiply and cause ulceration of the bowel with other sequelæ. For example, the giving of a purge will sometimes make a "cyst passer" pass the vegetative forms of amœba histolytica and very frequently an attack of amœbic dysentery is precipitated by an intercurrent attack of bacillary dysentery, which presumabbly facilitates the invasion of the bowel by amœbæ already there. In a tropical country the passage of cysts without any symptoms is often ignored even if in this country it would probably be wise to regard them as loitering with felonious intent. Sigmoidoscopy is essential in diagnosis. Every Guy's man ought to learn to use a sigmoidoscope. I imagine there has not been much opportunity during the War, but not least of the things which Sir Arthur Hurst taught was the use by every physician of a sigmoidoscope. When I went to Egpyt I found this knowledge extremely valuable, and I was surprised to find that some of the medical specialists, fully trained in every other respect, regarded a sigmoidoscopic examination in the light of a surgical operation. But I did not realise, however, until I became consulting Physician to the Army in North Africa and the Central Mediterranean, that what was a commonplace at Guy's was far from being so at other hospitals; when I issued a directive advising physicians to do sigmoidoscopies in certain cases and instructing divisional officers to make sure that all their medical officers became skilled in its use, there was a very considerable reaction, not only from many of the physicians, but also from many surgeons, who seemed to regard it as a dangerous form of poaching. Eventually, of course, the use of a sigmoidoscope became a routine for all physicians, and if a surgeon in a hospital proved difficult, he could always be converted by giving him twenty or thirty to do a week. The lesions, of course, are not always in reach of the sigmoidoscope but swabs from the mucous membrane are often positive even when the stools are not.

The main drug used in the treatment of amœbic dysentery is emetine, the alkaloid of ipecacuanha. This is given either as a subcutaneous injection of emetine hydrochloride gr. 1, or as emetine bismuth iodide by mouth in doses of 3 grains daily. Experience has shown that the latter method of administration is the most effective, but the preparation must be absorbed. In North Africa we found that the standard pills which were meant to be insoluble in the stomach but soluble in the duodenum were, in fact, insoluble anywhere and passed through the bowel without damage to themselves or harm to the parasites. I think many of the reported failures in treatment were probably due to this cause. We withdrew these tablets and substituted sugar coated tablets or else crushed up the E.B.I. tablets and gave them in cachets. Most physicians start the treatment with two or three injections of emetine before starting E.B.I., and some give injections throughout, but this method also accounts for some of the failures in my opinion, and it has been stated that such injections render the amœbæ emetine resistant. Whatever the method adopted the treatment is given for twelve days. It is usual then to give carbarsone 0.25 gramme twice daily for ten to twelve days, giving at the same time rectal retention enemata of 2 to 5 per cent. yatren or quinoxyl (quinoline sulphonic acid). The patient should be in bed on a residue free diet throughout the treatment. This is of necessity a very brief outline, but to get good results in treatment considerable attention to detail is necessary, and merely to go through the motions of treatment is doomed to failure and accounts for the many failures reported.

The amœbæ, of course, may invade the liver from the portal system and produce an amœbic hepatitis. This may be a diffuse inflammatory process with pyrexia, hepatic enlargement and tenderness. It may subside with or without treatment or go on without treatment to the formation of an hepatic abscess. These may occur many years after the original bowel infection and, in many cases, there is no history of any such infection although, of course, bowel infection must have occurred. The symptoms are pyrexia and a tender, enlarged liver. Often there is tenderness over the intercostal spaces over the liver and the diaphragm is raised and immobile, and often there is a dome-shaped swelling of the diaphragm where the abscess is spreading towards the pleura into which it may burst if it is not treated. It may also burst into the peritoneum and such abscesses must be palpated with care. Treatment is by injections of emetine hydrochloride, 1 grain subcutaneously, and this is often followed by a remarkably rapid disappearance of pyrexia, pain, liver enlargement and sometimes even of an abscess, although, as a rule, if an abscess has formed aspiration must be carried out. Cases which end fatally have usually been missed until too late, and again it is a condition which can be diagnosed by thinking of it, aided and abetted by an aspiration syringe.

There are many other tropical diseases which I could mention as possible occasional visitants to our out-patients' and wards, but I have not time to refer to them.

You may wonder whether any of the diseases I have mentioned may become endemic in this country after their introduction from abroad. In the case of malaria we have the experience of the last war to guide us. Quite a large number of cases of malaria occurring in people who had never been out of England were recorded in the years immediately after the last War. There are plenty of anopheline mosquitoes in this country, although, of course, they have not so far been infected with malaria, but probably many of them will bite infected soldiers from abroad and there have already been and will be more primary cases arising in this country. I have already diagnosed malaria in the case of a woman who has never been outside East Croydon, but I have no laboratory confirmation and it may merely be that I have a bee in my bonnet about the disease.

The mode of transmission of kala azar is not known for certain, although dogs and squirrels are susceptible animals; the probable vector of the disease is the sand-fly which does not flourish in this chilly climate so that the disease is unlikely to gain a foothold in this country.

Amœbic dysentery as well as bacillary dysentery is spread by fæcal infection and carried either by infected hands, utensils or by flies. In the countries where it is common, vegetables are often cultivated with human manure, which is, fortunately, not an English practice and the standard of hygiene and sanitation is, in general, so good that flies are unable to become infected, so that although food handlers who are carriers will probably be responsible for a few small epidemics, no serious spread need be feared.

Pantomime at Orpington

THE County Hospital at Orpington is fortunate in possessing a large recreation hall and a fine stage, originally built by the Canadians during the first World War, surmounted by their crest and motto *Ut Incipit Fidelis sic Permanet.*

Recently it has seen six performances of "Mother Goose," entirely produced and played by the Nursing Staff, mostly Guy's. The gaiety and freshness of the performers and the many colourful costumes and changes of scene left not a dull moment throughout the show. Among the outstanding performances was that of Sister Davies as "Mother Goose"; while that of Sister Smyth, as "Priscilla the Goose," was shapely and elegant. Her movements, and the look in her eye, charmed everyone, especially the many children, who saw her. Other outstanding performances were given by Margaret MacNab (Fairy Queen), Minokshi Joshi (Lucifer), Joan Wastrell and Mary Woolmer (the Clowns), Joan Cranley (Jane), Mary Willis (Lizzie), Sister Wall (Principal Boy) and Daphne Glasgow (Principal Girl).

To Mrs. Bevan, formerly a V.A.D. in the Hospital, is due the highest praise, not only for her own acting as Harlequin and Sailor Boy, but for her hard work and skill in training to such perfection all those who took part. The various audiences comprised —Patients, Old and Young, Service and Civilian, Children from the Catholic Orphanage, Medical, Nursing and Domestic Staff with their families and friends, and many good friends of the Hospital living in and around Orpington.

The Guarding of Guy's

BY H. ST. H. VERTUE.

(After *Scotish Ffeilde*, Percy Folio. It would be best to read this ballad aloud.)

Grant, gracious God : grant me thy grace,
That I may & sing : their selven to please,
Those kempes keene : & knights full comely,
That were chosen of the chief : though their chance was the worse,
To byde them in this HOUSE : & hie them not hence,
But settle them to the fight : & stand steadfast in place,
In the day of darkness : in the night of dread.
In the place of jeopardy : in the years of peril.
When that foulest freake : that formed was ever,
He that Hitler hight : all his hosts had gathered,
First fared he into France : & fought that folk full eagerly ;
They were beaten at the first brayd : & bowed to his hands.
Then all his seege he summoned : & sent them against us,
And bade them enter England : & venture them selven,
To win it in war : & welde it to his lykinge ;
And many a selcouth sailor : to shogg into ship
That wended under water : & scath did to many ;
And all his hosts have hett : that through the air ranged,
That they rake them well forward : & wreak a red ruin,
And with many a derfe stroke : ding us to death.
And quite overbear us : & with bombs batter us down,
And our towns overturn : & all bring to nought ;
But most upon lief London : his lewd wrath would he let loose.
Then every man of ours boldly : bowneth him to the battle.
Some were that wended : over weltering waters,
And were faren from home : afar over the broad flood,
Some into Kent came : & coasten into that country,
To wait in that ward : & there wit the wing :
But I tell you of those : that hereupon tended,
And in lief London lay : where their lank lot longed,
And guarded well this great HOUSE : & surely all things guided
For him that built it rightly : that was GUY OF GOOD DEEDS.

They were brave bearnes : that bowed not their heads ;
They fled not in flight : nor of naught were afraid ;
They were of courage the core : they were of a wise counsell ;
They were comfort also : & courteous of deeds.
Of woundes they were wise : & of sicknesse they wote well ;
They were breme as boar : & they were blythe of blee.
I will carpe of their names : their noblenesse to kythe,
That forgetfulness befall not : for friendship's sake,
And for remembrance : a tribute trulye paid.
Then well will ye wit : to what wights ye worshipp owe.

More manful meanye : was never of this mold made.
There was Bishop that bold bearne : that bred forth the battle,
And Lloyd that dear lord : that led as him likened ;
And that dear dame : that doughty was ever,
The wise Wittrick : she had worshipp in warfare.
These were lite lords & lady : & led at their will.
Kilpatrick, that knight of courage : he was of their counsell,
And Wass that was wise : and warriour full witty.
Blaikley that brave lad : that blann not of striving,
And Shein that was of a sure strength : these were proved of deeds.
Then they that of Works wot : their wit never wanted ;
These burgesses busked them : to battle full briskly;
They were faithfullest found : from no fear would they flee.
The seemlye Sisters : for the seige were able ;
And men & maidens : the jolly meanye.
The stalwart students : I trow they stood stoutlye,
And the gentle nurses : Jesus bring them to joy.

When it darkened full dimlie : & drew towards nightfall,
When the last leames of light : left the lowering sky,
And from far & from near : fell the fearfullest howling.
As of wailing of lost wights : in a world full of woe ;
When on the griefful ear : grew a great noise of grinding,
That was a grislye sound : & grated full sorely ;
Then knew they these valiants : that the caytiffs were comen,
All that cursed crew : in their cruel engines,
Full unmeet for man made : mischief them befall !
Then they were of a high heart : & haughtytheir will was,
They bate not of boldness : for no bearne upon live,
But bode by their banners : the bearnes of that household,
And stood to their standards : every man in his stead.
Anon came the onset : with uproar appalling,
The rattling & rumbling : rang far over field
The gurding of guns : & the grinding of engines,
The shooting of shells : & the hissing of missiles,
The bursting of bombs : & the blasting of buildings,

The shock of the hit : & the sound of the shattering,
The masses of masonry : falling & crashing,
The roar of the rubble : that ran into ruin,
Hoarse breath of the fire : & the flames flying upward,
The death & the danger : till dawning of day.

Then fettled them the poor folk : to flee hither swiftly ;
To this HOUSE would they keere : their comfort to seek,
That was wont in all ways : to wait on their welfare.
Bearers busked them hither : brought many on bier,
That sorely were stricken : man & maid. young & aged,
The bourde & the babe : all bloudye beronen.
When the blood brast out : & the limbs were broken,
And with grit were begrimed : that grievous to see was,
And stank full foully : & the flesh was tattered.
In the deadly stowre : they sweltered & swounded.
Many souls swiftly : were snapped to the death,
Things uneath to tell : the Lord them amend !

Then our men & women : met at their muster,
All in goodlye haste : bradd to their business,
Full radlye in array : attilde them to their tasks.
They were no cravens : they set about calmly :
Bombs they set at nought : so I trulye tell ye ;
Among fires & flames : they fought full freshlye :
Safety they sought not : they served others forsooth.
It was a seemlye sight : to see them to- gether ;
There was order I hett you : as the dear God ordained.
All those wounded churls : they cherished them cheerlye ;
Among this poor people : they were pillars of peace.
They stinted no succour : of their skill they scanted not,
That were of wate wisdom : to e dread wounds to tend.
They scoured the skin : & of crudded blood cleansed it,
The maimed & the marred : they mended & made straight,
They joined with their art : the mangled members,
The rent corse restored : & aright redressed it.
Into the shrunken vein : the lifeblood they dripped & drained,
From the dore of Death : the foredone were delivered.
With the mighte of Medicine : their pains they put clean away ;
Into slumbers & swoonings soft : they lapped and lulled them.
Women of wondrous worth : with winne words welcome bid ;
They kenned them so kindly : they cared no more.
They greeted them goodlye : & gave them good easements ;
Drinks they gat & draughts : that the bodye well pleased.
With their hands they washed them : was never so sweet tending ;
Their sores they salved : & handled them softlie ;
They bound them up wisely : that well they might heal.
Some that were hendy : home at their hest went ;
Some they rede tarry : till their plight were better ;
To the bed they brought them : to bide there & rest.
Thus was it forsooth : while the long night lasted,
Fear was forgotten : Love was leader & lord,
Till the noyous night was over : & her hateful hue had hidden,
And the last lodlye engine : skulked from the light.

Then the sun shott up : & shone over fielde,
With leames full light : all the land over,
That was solace to see : for any seege living.
They fettled them full speedilye : their fast to break.
To their work they wenten : they were weary, I weene,
But they lin not of labour : they laid them not down,
Never daunten nor downcast : they were lions iwisse.

Then all those Germans : with a great host,
Gorged with their gains : griping with greed,
Raked into Russia : ran over that realme,
With a route of robbers : scoured over the steppes,
Their strongholds stormed : swarmed into their cities :
And lief London left : while they laid them about.
But the mightye Muscovite : had a mind for that meanye,
Dinted them with derfe strokes : & drove them back surely.
Again then the ruthlesse route : to their rancour returned,
And the fierce foemen flew : & fell upon London.
But many a gaping gun : gave them good welcome ;
Stalwart our gunners were : stoutlye they shotten,
Blew up their engines with a burly blast : brast them in pieces.
Life caytiffs were they killed : care them be happened.
They fled away for feare : so ill they fareden,
That no alyant durst any more : hither adventure.

When all these wicked wights : wist they outwitted were,
They waxed woode & wayes set : to work us a worse woe.
Rockets they shotten out of sky : that a sore scath diden,
That burst with a great blast : & all the ground gogled.
Many missiles too they made : that marvels to see were ;
Manless through air they glode : madly swooped downward,

Flame & fire flashed forth : & a fell crash followed,
And where had buildings been : but a black smoke belching,
Houses battered & bett : homes broke in pieces,
And many folks foully : done to the death.
Thus dealt they dearfe dints : by day & by night
On wight & on wife : & on winne children.
No truce at no moment : no time was for trust,
But the limbs might be lost : & the life both.
But merrie was the meanye : of our men & women;
They halched them heartily : had no mind for hiding,
But boldly looked forth : & were never abashed,
Nor went from their wits : for wayling care.

Thus lay they & lodged : the length of six years.
Then there came a herald : with these faire tidings,
"All ye brave bearnes : of Brutus' seed,
That were bred up in Britain : joy of your joyings!
Now is this ferle field : foughten to an end.
Boote after bale comes : the battle is ours!
Brent is that butcher : with his leman beside him,
The hosts of the heathen : are slaughtered & scattered,
And all their cursed lords : killed or made captive.
Lo, their reward : that the Fiend serve!
He that fights England : fights fate, for- sooth.
Right is requited : the realme is restored."

But woe was the world : that the warfare had wasted,
The HOUSE still stood : & the stalwarts that served it,
But a wan waste of wreckage : & rubble lay round it,
And bitter the bale : upon biglye buildings,
All, all brought down : but the HOUSE OF GUY.
For his bearnes wote well : of his words of wisdom,
"Better giving than getting" : & greatly they gave.
The HOUSE still stands : be it sorely smitten;
Still styes to the heaven : the tower of Hunt;
Ye may see from afar : & greet it goodlye.
And gladly the guerdon : give to the guardians,
Heart of homage : & tongue of thanks.
And he that this geste made : he is right judge, by Jesu!
He carpeth full truly : wits well what he kythes.

At the hearthstone of GUY : there is gathering & greeting;
The sons that set forth : over sundering seas,
That were fain of the fray : & fared far for the fighting,
Home have they hied them : & hendy their hap be!
Then, lordings, learn well : of the lot that them longed,
That wonned there in warfare : & right well it warded,
That of will never weakened : of wit never wanted,
Nor went from their wonning : for waile or for woe;
But stayed & were steadfast : sate not in sadness,
Struck & stood stoutlye : stern were in striving,
Swift to the succour : shield of the stricken,
Strong in the struggle : & stiff in the stowre.

Correspondence

"THE WILDERNESSE."

To the Editor of the GAZETTE.

SIR,—It is with great regret that I have to report that the Guy's "U.S.A." Hospital, "The Wildernesse," Seal, near Sevenoaks, was closed to patients on December 14th last, and the building handed back to the owners on December 31st, 1945.

Many queries have been received as to why this branch hospital was not retained, in view of the grave shortage of beds at Guy's. The position is that the lease of "The Wildernesse" was for the duration of the war with Germany and three months thereafter, and this lease therefore expired at the beginning of August, 1945. However, through the generosity of the owner, Mr. G. E. Fawcett, Guy's were permitted to remain in occupation until the end of the year. It should be noted that the rent paid for these premises throughout the five years' occupation by Guy's has been one shilling per annum.

The Governors have expressed their sincere thanks to Mr. Fawcett, and also to his staff who have worked hard and willingly to assist in the hospital. Thanks are also due to the local residents, too numerous to mention individually, who have been of the greatest assistance in the successful working of this branch of Guy's.

If this letter should come to the notice of any of our American friends who did so much to make possible the opening of the Guy's "U.S.A." Hospital, I should like to assure them that it has been a great asset and an invaluable help in dealing with the work which has fallen on Guy's medical, surgical, nursing and administrative staff during the War.

Mr. Fawcett has assured us that he and all others connected with "The Wildernesse" are exceedingly sorry that the pleasant associations of the past five years have had to cease, and on behalf of all at Guy's I am sure I can say in turn that we also very much regret the end of this war-time activity.

Yours faithfullty,

JOHN E. HUMPHERY,
Treasurer, Guy's Hospital.

Sport

Rugby

GUY'S *v.* LEICESTER.
(*At H.O.P., Saturday, December 8th*, 1945.)
Result: Guy's, 6 points; Leicester, 5 points.

The Guy's side against Leicester had an unfamiliar look, the result of injuries; but the will to win triumphed over the disorganisation thus caused and over the effects of the cold. The Leicester forwards had the better of the scrums where Guy's did not pack too well, but their halves were the more incommoded by the cold and did not make the best of the advantage. On the other hand, the determined vigour of the Hospital forwards in the loose set up attacks at intervals throughout the game and Guy's always looked just the more likely to score, though the Leicester threes were the better together.

Mishandling by both sets of backs could fairly be put down to the weather, but the Guy's fly-half and centres could not blame the cold for bad judgment in timing their passes—they either handed the ball on without drawing their man or held on till they were put down. Van der Westhuizen sometimes looked dangerous, but he is never really happy at right centre. Nevertheless, the threes joined very nobly with the forwards in a number of combined rushes, while an attractive feature of the game was the way in which the two full-backs, playing as outside threes, kicked to make ground. Some of Le Clus' touchfinding after he had been hurt was as clever as it was plucky.

Leicester scored first—K. R. Harris running nicely to score behind the posts, and the try was converted. And so, although Lewis almost kicked a penalty, Guy's were five points down at half-time. The game had always been interesting, and interest grew in the second half as both sides attacked in turn until it became really exciting as Guy's stormed up to the Leicester line, for McCallum to score far out ten minutes from the end. The kick just failed. The rest of the game was in the best Guy's tradition, and the attack was kept up till Lewis had the chance of a penalty to kick a fine goal and secure a fairly earned victory. Both full backs did well, with Lewis the sounder of the two, and his steady return towards his old standard of play is good to see.

GUY'S *v.* WASPS.
(*At Sudbury, Saturday, December 15th*, 1945.)
Result: Guy's, 3 points; Wasps, nil.

There were writers in the Press who proclaimed that the Wasps would win this game, but, although the match was hard fought, anyone who watched it must have wondered at so confident a judgment. The fact is that Guy's won and well deserved to win. Perhaps the powerful Wasps' pack took just more of the set scrums, but Guy's were definitely faster and cleverer in the loose, and the tackling of Carton-Kelly, Ekstein and Walker, the back row forwards, was outstanding. Behind the scrums and the loose mauls A. A. Bailey can congratulate himself on his duel with P. W. Sykes. The Guys' backs made more constructive moves than did the Wasps, though Till and Grimshaw were determined and dangerous in the Wasps' centre. Guy's scored in the second half from the best bit of play in the match—a beautiful piece of combined work and determined running, in which the ball travelled along the threes to Le Clus, who ran splendidly and rounded Seal, to return it along the line till it was seized by Dean, who thrust over for the try which, as the ball was heavy and wet, was not converted.

In the first half the Wasps had more of the game and owed a good deal to accurate touch finding, but then Guy's made several movements which threatened danger and, from one of them, went over for what looked like a try, but which was disallowed. After the interval the attack was renewed and Guy's maintained the mastery they had established until, after some twenty minutes, they scored. Wasps rallied and fought back very hard, but Guy's returned to the attack, and Wasps had to resort to admirable kicking to save their line from being crossed. And so the end came in the gloom and with no further score.

Lewis was a tower of strength at full back and his steadiness on the slippery ground, against persistent attacks, was a great factor in the win. The Guy's backs have been praised already. Van der Westhuizen was as penetrating as ever, but he should learn to pass more to the right and thus make full use of his right wing three-quarter.

GUY'S *v.* RICHMOND AND BLACKHEATH.
(*At Blackheath, Saturday, January 5th*, 1946.)
Result: Guy's, 17 points; Richond and Blackheath, 8 points.

Guy's made their first appearance at Rectory Field since November, 1933, and succeeded in defeating the combined Richmond-Blackheath side by 2 goals, a dropped goal and a try to a goal and a try.

At first glance this result looks creditable, but it must be remembered that the combined side are still without a victory this season and so our players should not feel unduly elated. Nevertheless, such a good start to the second half of the season augurs well for the approaching cup-ties and, no doubt, Hilliam, who played his usual tireless game in leading his pack and welding the players into a solid team, was well pleased with the result.

Guy's opened in a most lethargic manner and found some difficulty in preventing

J. G. W. Davies, the Blackheath centre, breaking through and sending J. J. Remlinger away on his corkscrew runs. Several times the combined side came near to scoring in the first quarter of an hour, and only some excellent tackling by Macrae-Gibson and D. Le Clus stemmed the tide. The pressure was, however, too much, and J. J. Remlinger scored a solo try by kicking ahead and touching down. Thereafter, Guy's pulled themselves together, and Van der Westhuizen intercepted a pass on his own "25" line to dash through and send Macrea-Gibson over for a try which D. Le Clus converted. The combined side had the misfortune to lose A. A. Smailes, their scrum-half, just before half-time, and this handicapped them for the rest of the game. B. M. Gray, normally a full-back but playing at scrum-half, was quick to seize on this weakness and gave his backs a good service, which Van der Westhuizen exploited admirably although the latter's brilliant runs did not always bring the success they deserved as there was some doubt as to whether he made sufficient use of the undoubted ability of Macrae-Gibson to round off the movements. It was therefore left to D. Le Clus, on the other wing, to shine in attack and he caused the opposing defence, especially J. J. Remlinger, a lot of trouble.

Guy's took a long time to master this combined side, and it was not until Van der Westhuizen dropped a goal from about 40 yards out that the result was safe. Shortly afterwards H. Wolfsohn, a last-minute substitute in place of A. G. McCallum, scored an unconverted try which was followed by an excellent try by D. Le Clus, who also converted.

In the closing stages Guy's were on the defensive, but the forwards were not in the same forceful mood as they were against South African Services and, following five minutes of hard pressure, E. B. Norton touched down for a try, which J. G. W. Davies converted.

Outstanding in the Guy's pack was Ekstein whose dribbling and solid tackling was first-class, and the captain need have no fears about Wolfsohn, who made a most impressive first appearance. The surprise of the afternoon was the fine display of Gray at scrum-half who, without any frills, got the ball away to Dwyer with an accuracy which would have done credit to a far more experienced player in this position.

Hospital Information, etc.

Notices

GUY'S HOSPITAL DENTAL DEPARTMENT.

Applications are invited for the post of Administrative Dental Officer. The post is primarily an administrative one under the supervision of the Superintendent of the Hospital. Attendance on six mornings per week from 9 a.m. to 1 p.m. The appointment is an annual one, and the holder is eligible for re-appointment for a period of five years. Salary: First year, £350; second year, £375; 3rd, 4th and 5th year, £400. Candidates who must possess a registrable qualification, should forward their applications to the Dean, Guy's Hospital Medical and Dental Schools, London Bridge, S.E.1, not later than January 31st, 1946.

THE COMMONWEALTH FUND FELLOWSHIPS.

The 1946 memorandum on the above has now been published. Information on the subject of these Fellowships will be of considerable interest to many readers. Full particulars and application forms may be obtained from the Medical School Office, Guy's Hospital.

Change of Address

F. J. H. Edmonds, L.D.S., R.C.S., 79, The Promenade, Cheltenham, Glos.

Ellis G. Garnett, Jnr., L.D.S., R.C.S., 134, Sandgate Road, Folkestone, Kent.

E. K. Hudson, F.R.C.P., 135, Harley Street, W.1, and 6, Morland Close, Hampstead Way, N.W.11. (Tel. Nos.: Welbeck 4343 and Speedwell 8696).

G. S. Loader, L.D.S., R.C.S., 29, Devonshire Place, W.1. (Tel.: Welbeck 6166.)

R. G. Siggers, L.D.S., R.C.S., Gallants, East Farleigh, Maidstone.

Papers by Guy's Men

Spriggs, Sir Edmund. The Harveian method in literature (The Harveian Oration, 1944.)

Harvey, Warren, and Another. Acceleration of the setting of Zinc Oxide Cements. *Brit. Dent. J.*, 1945, 80, 1.

New Year's Honours

K.B.E. (Military).

Maj.-Gen. William Heneage Ogilvie, D.M., M.Ch., F.R.C.S.

Air Vice-Marshal Charles Putnam Symonds, C.B., D.M., F.R.C.P.

K.C.I.E.

Maj.-Gen. (local Lieut.-Gen.) James Bennett Hance, C.I.E., O.B.E., M.D.

C.B. (Military).

Air Vice-Marshal A. F. Rook, O.B.E., F.R.C.P., K.H.P.

M.B.E. (Civil.)

Douglas Alkins Skan, M.R.C.S.

The Services

Awards in recognition of gallant and distinguished services while prisoners-of-war.

O.F.E. (Military).

Lieut.-Col. G. T. Hankey, R.A.M.C.

Mentioned in Dispatches.

Captain A. Crook, R.A.M.C. Captain F. B. Lake, R.A.M.C., Captain I. McD. G. Stewart, R.A.M.C.

Births

STONEHAM.—On January 13th, 1946, at Nuffield House, Guy's Hospital, to Pauline (née Walker), wife of F. J. Russell Stoneham a daughter (Angela Russell).

SUSKIN.—In December, 1945, in Johannesburg, S. Africa, to Audrey (née Harris) wife of Michael Suskin, L.L.S.—a daughter.

Deaths

FRANKL.—On January 7th, 1946, at Cambridge, after a very brief illness, Guy Richard, son of Ernest and Carmen Frankl (née Hough), aged 17 months.

EDS. {J.M.H. R.H.N.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

SOME interest has been aroused by the introduction of a substantial number of ex-Service men as house-officers at Guy's and within the Sector, in accordance with the Government's scheme for the "rehabilitation" of medical officers released from the services. It has been decided that no one qualified for more than nine months shall hold a resident appointment during the present period, and it may later become necessary, if more Service men appear, to reduce this proviso to six months. The A, appointments are being allotted to those who have just qualified, and many of the B. 2. appointments are being given to ex-Service men.

THE Residents recently held a dinner in the College, the third they have held since 1940, and one which successfully helped to adjust a situation whereby not all the Residents were well known to each other.

To the retiring President of the Residents, Mr. A. Batty Shaw, and to the Vice-President, Mr. J. D. L. Reinhold, we extend our best wishes. They are being succeeded respectively by Mr. C. H. Kinder and Mr. K. D. Allanby. The former also takes Mr. Batty Shaw's place on the Residents' Ball Committee. In order to bring the Ball to the notice of as many old Guy's men as possible. it was advertised in *The Times* and the *Daily Telegraph* last week. It is to be held at the Dorchester Hotel on Friday, March 8th, 1946. Time is passing and immediate application for tickets—two guineas for double tickets—is advisable. These should be obtained from the Secretaries of the Committee, cheques being made payable to Guy's Hospital Residents' Ball.

THAT antiquity is not necessarily a voucher for efficiency is a postulate often ignored. Bearing it in mind we ask, "What is the purpose of Firm Dinners?" Certainly they have become a tradition, but that does not automatically infer that the tradition is a good one. Whether Firm Dinners do, in fact, serve any useful purpose whatever is highly disputable.

A commonly accepted excuse for holding a dinner at the end of a clinical appointment is that it stands as a token of appreciation of all that the Honorary and Registrar have done during the preceding three months. Some people, with a wider sense of justification, would declare that the dinner also provides an opportunity of learning, at first hand, the opinions of their seniors on the more important topics of the day.

In actual practice these admirable excuses are little more than a mask for the underlying desire of the hosts to spend a gay, alcoholic evening—with the guests as inconsequential participants, or even as mere onlookers. As a result the guests must surely obtain a distorted conception of current methods of showing gratitude, and we wonder whether opinions, if aired, are susceptible to comprehension.

We doubt whether our teachers always enjoy the Firm Dinners which they attend with such commendable regularity every three months. It is possible that they accept the invitations to these functions simply because refusal is embarrassing to them, or because, being on the same plane as most mortals, they are not unmoved by the claims of beer—especially free beer. Whether they approve of the manner in which the evening usually—we might almost say invariably—proceeds, or whether, indeed, they are frankly bored is problematical. As far as gratitude to one's teachers is concerned, then we suggest that it would be more acceptable to them, and probably less costly. to present them at the end of an appointment with a bottle of whisky or some suitably inscribed gift (if that should be deemed more appropriate). This would, in addition, obviate the necessity of issuing an invitation and the uncertainty of having it accepted or refused.

We are very much in favour of an exchange of views between teacher and student, but we are not convinced that this can best be carried out at the "Prospect of Whitby" or in Soho. It has been the practice in some hospitals, and we believe that it was formerly the practice here as well, to foregather during an appointment at the house of the surgeon or physician. We realise, however, the well-nigh insuperable difficulties of such a procedure at the present time. But there are places—we can think of one within the Hospital boundaries—where a quiet, informal dinner could be held and at which the brain might primarily be stimulated by coffee rather than depressed by alcohol.

There remains one further point which requires consideration, and it concerns the younger members of a Firm. A meeting of dressers or ward-clerks, at some convenient place where the atmosphere is a beneficial one in which to celebrate (or bemoan) the end of an appointment, has much to recommend it and need not be elaborated here. Together they could toast, applaud, condemn or imitate their seniors—without restraint and, we insist, without the Hospital.

It is a sad fact that few students now at Guy's (we hope they are few) can have read a notice announcing a meeting of the Physical Society and so it is with particular pleasure that we refer them to the announcement under Hospital Information. The Physical Society has an undoubted claim to be one of the oldest medical societies in existence, and with it have been associated many famous Guy's men. The meeting shortly to be held—the first since the days before the war—is therefore of very special significance.

We are sure that Dr. Campbell's interesting article, "Orpington, 1939–1945"—the first part of which we publish in this issue—will appeal to all our readers, and not only to those who were associated with Orpington during the War. It continues the series started by Dr. Bishop's article, "Guy's and the German War."

Prostatic Obstruction

A Clinical Lecture delivered at Guy's Hospital on Tuesday, January 22nd, 1946, by

W. D. DOHERTY, M.Ch.

GENTLEMEN,—I propose to talk to you about obstruction to the outflow of urine caused by enlargement of the prostate gland, its causes and effects.

It is customary to divide the urinary tract, for descriptive purposes, into an upper urinary tract, consisting of the kidneys and ureters, and a lower urinary tract consisting of the bladder and urethra, and we shall consider the effects of obstruction on both these systems. Let us consider, first, the CAUSES of prostatic enlargement which may give rise to obstruction. They may be:—

1. *Inflammation*—
   A. Acute.
   B. Chronic.

A. *Acute inflammation* of the prostate gland may occur as an ascending infection in the course of an inflammatory lesion of the urethra. This may be the cause of acute urinary retention during an attack of gonococcal urethritis; on the other hand, acute prostatitis going on to abscess formation may be a blood-borne infection. I have seen acute retention of urine in a young man due to a staphylococcal abscess in the prostate gland secondary to a boil on his neck. The bacillus coli is also a common blood-borne organism.

B. *Chronic prostatitis* may result from an acute infection which has never been quite eradicated, or it may follow infection by an organism of low virulence. In either case it is very common for calcium salts to be deposited in the gland with the formation of prostatic calculi This is a similar pathology to the formation of salivary calculi in the submaxillary gland. The irritation of the calculi, from time to time, causes a flare up of the prostatic infection with resulting obstruction. In addition, the surrounding fibrosis gradually contracts and narrows the bladder outlet.

2. *Simple hypertrophy* of the prostate gland is the commonest cause of urinary obstruction. Under this heading we will include the so-called adenomatous enlarge-

ment, in fact, all the types grouped under the heading of senile prostate enlargement, although they may come on long before senility makes its appearance in other parts of the body. I think there is no doubt this enlargement, which may occur in a man from forty years onwards but is commonest round about the seventies, is due to a hormone imbalance, but so far little more is known about it.

It is the normal routine for the prostate gland to atrophy in old age, but in something like 30 per cent. of men the gland undergoes enlargement instead, which is generally progressive at varying rates. Probably 15 per cent. of men get obstructive symptoms. It is therefore a very common pathological lesion.

3. *Carcinoma of the prostate gland* is, unfortunately, a common disease. About one-fifth of the cases with symptoms of prostatic obstruction which come to out-patient clinics will be found to have malignant disease.

Carcinoma of the prostate gland does not, however, always give rise to obstruction. Sometimes the patient presents himself with secondary deposits, commonly in bone, without any urinary symptoms at all. This is one of the reasons why a ROUTINE examination per rectum is so important in all surgical conditions.

During the last few years it has been conclusively demonstrated that the growth of carcinoma of the prostate is readily influenced by hormone therapy, although it is not clear whether hormone imbalance is the causal factor.

EFFECTS OF PROSTATIC OBSTRUCTION.

Nature reacts in the same way to obstruction in one of the vital passages in the body, be it in the vascular system, the alimentary, respiratory, or urinary tract. First of all there is hypertrophy of the muscular wall of the passage above the seat of the obstruction, so that the contents are forced through the narrow portion. If the obstruction is a progressive one there comes a time when the hypertrophy can increase no further and the effects of the obstruction become manifest—namely, there is a damming back of the contents with dilatation of the passage above the obstruction, the passage does not completely empty and eventually does not empty itself at all, becoming completely obstructed.

The bladder may be considered as part of the passage through which the urine passes on its way from the kidneys to the exterior, and I want to consider the effects of the obstruction in this passage in three stages :—

Stage 1.—*Complete Compensatory Hypertrophy.*
Stage 2.—*Commencing Failure of Compensation.*
Stage 3.—*Complete Failure of Compensation.*

Stage 1.—In this stage there is a gross hypertrophy of the bladder, but the bladder completely empties itself at each act of micturition. The bladder wall will be found to be thickened, the muscle bundles standing out clearly underneath the mucous membrane. There are no pathological changes to be seen in the upper urinary tract, the kidney pelves and ureters emptying normally.

The *symptoms* at this stage will be due to the loss of elasticity and capacity of the bladder due to the hypertrophy. Hence frequency, urgency and diminishing stream, with slowness in initiating the act.

If during this stage the patient should get a gross prostatic congestion from sexual excitement or an over-full bladder he may get a sudden and complete obstruction, acute retention, which, when relieved by catheterisation, leaves him as he was before, with a compensated obstruction.

It is my custom to investigate all cases of suspected urinary obstruction by intravenous pyelography and cystography.

The patient is instructed to come to the examination with a full bladder. Pictures are taken of kidneys and bladder at three, eight and fifteen minutes after the injection of the dye. The patient is then instructed to empty his bladder and a further picture is taken. The dye excreted in the urine makes the full bladder outline stand out clearly, and the picture taken after micturition shows whether the bladder empties or not. At this stage the pyelogram and cystograms will be normal except perhaps for a little irregularity of bladder outline due to the muscular hypertrophy.

Stage 2.—In this stage of commencing failure of compensation the most striking change is that the bladder fails to empty itself at each act of micturition and the patient begins to get *residual* urine left in the bladder.

The whole bladder wall begins to lose tone and dilate, or else the mucous membrane tends to herniate between the muscle bundles, producing *diverticula*.

The effects of the obstruction begin to become manifest in the upper urinary tract and the muscle fibres in the wall of the pelvis of the kidney and ureter hypertrophy in order to empty themselves into the bladder.

Another complication which may occur is stone formation—in the stagnant residue in the bladder or, later in, the pelvis of the kidney.

The symptoms during this stage are sometimes less marked than in Stage 1. The loss of tone in the bladder musculature may make for less frequency and urgency of micturition, so that the patient thinks he is better. There is no sign of any renal failure and blood chemistry will be normal.

As before, an attack of acute retention may occur at any time and can be relieved by catheterisation.

The diagnosis is made by intravenous cystography, which shows the bladder dilatation and possibly diverticula. It also shows the presence of residual urine with some measure of the amount.

Stage 3.—This is the stage of complete failure of compensation. The bladder becomes grossly dilatated with a large volume of residual urine. The kidney pelvis and ureters are unable to empty themselves into the overdistended bladder, so that bilateral hydroureter and hydronephrosis results. The pressure of the urine in the hydronephrosis causes ischæmia of the renal parenchyma with resulting atrophy.

The conditions one of chronic urinary retention. The bladder is distended often to the umbilicus, but is quite painless, in contradistinction to the acute retention, which is painful.

The patient has gross frequency which goes on to incontinence. This generally first makes its appearance during sleep; in fact, an elderly man complaining of nocturnal incontinence is almost certainly suffering from chronic urinary retention.

There will also be signs and symptoms of renal failure, evidenced chiefly by cardiac and circulatory incompetence. The diagnosis is not difficult so long as the distended bladder is not missed by the examining hand.

Intravenous pyelography and cystography is contra-indicated and, in fact, will be of no value as the failing kidneys will not concentrate the dye.

TREATMENT OF PROSTATIC OBSTRUCTION

This must be briefly outlined. The inflammatory conditions must be treated on general lines with sulphonamides, draining of abscesses, etc. The presence of prostatic calculi may require a prostatectomy to eradicate them.

Carcinoma should be treated with stilbestrol 5 mgm. daily by mouth and, in most cases, obstructive symptoms will be relieved.

Senile enlargement calls for different treatment in its three stages.

Stage 1.—This is the ideal case for a one-stage prostatectomy by which ever route the surgeon favours.

He will tell the patient that the condition is a progressive one, that he can have an operation now and be healed and about again in three weeks' time with a minimum of risk. Whereas, if he waits until a later stage, both the length of time and the risks of the operation will increase.

Stage 2.—A patient in this stage may again be subjected to a one-stage operation, but complicating factors such as diverticula or stones may call for a two-stage procedure.

Stage 3.—This is the dangerous stage owing to the renal and circulatory failure.

The bladder should be drained, preferably by a supra-pubic tube and the pressure let off slowly, to minimise the hæmorrhage which frequently occurs into kidneys and bladder as the pressure is reduced.

The drainage must continue until the renal and circulatory failure has been stabilised. It will seldom return to normal but, once it has reached a stable level, these elderly patients stand a prostatectomy very well, and it is not often that they are forced to remain with a permanent supra-pubic tube.

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Orpington, 1939—1945.

By MAURICE CAMPBELL, O.B.E., F.R.C.P.,
Medical Superintendent, Orpington County Hospital

"ARRANGEMENTS have been made for the transfer of eighty-seven nurses from Guy's Hospital to the Orpington Institution should a state of emergency arise. Transfers would be effected on three consecutive days, the first transfer to synchronise with the second day of the evacuation of school-children. . . . Each nurse is instructed to bring a suit-case containing the minimum of personal belongings, uniform, etc. It is appreciated that for the first few days staff accommodation for staff being transferred may not be available, but pending the completion of billeting arrangements which are in hand staff must, if necessary, use patients' accommodation." So ran a laconic message received by Mr. Dowers, the Master of the Orpington Public Assistance Institution a few days before the War started.

September, 1939, will recall many poignant memories, and two pictures of Orpington, that were to become such a large and busy hospital throughout the War, may serve to introduce the story of its growth and work. They are from Sister Heap, who was the first Guy's night-sister and was afterwards in charge of Ward 3, Mr. Doherty's genito-urinary ward, for four years; and from Brian Johnson, who came and went so that he formed three separate impressions of the hospital at its birth, during its adolescence and in its maturity.

"September 3rd is a day which will always linger in my memory. We all dreaded leaving our beloved Guy's. With seven sisters and numerous nurses we found ourselves at Orpington, a hutted hospital of the last war, to prepare for casualties at any moment, Our first evening was spent finding accommodation. The next morning arrived free from bombs with the sun shining from a cloudless sky, but depression set in later when we inspected our new hospital. Four wards had been emptied (literally); the only items remaining were bedsteads and chairs, not even a cup and saucer was left. The next month was spent in making these wards habitable, walls were washed, floors were scrubbed and polished, and beds renovated and made up.

"The preparation of an empty ward for the reception of patients is by no means an easy task when everything is to hand, but here to provide even the bare essentials —to say the least of "comforts," such as air-rings and dressing-gowns—was an anxious task. There were few cupboards, so we had to make do with orange-boxes. What a boon they proved! We collected make-up jars and pots of all descriptions for our drug cupboards and treatment trolleys, and also made up saline, sterile solutions, ward dressings, and stock. Having got the wards ready many sisters bought paint and brightened up our duty rooms. Pictures and flowers helped to remove the uninviting atmosphere of these rooms. In addition to all these task all the windows in the old block, some 2200 window-panes, were blacked out with the help of some medical and massage students. The wards had no sterilisers and for some years this had to be done in fish-kettles over a gas-ring."

"My first impression of Orpington was made on the first day of the war. I was a senior dresser and had, on instructions, rushed down importantly clinging to my 'dresser's instruments in morocco case—complete' with the idea that I was to work in a large hospital, to help the poor victims of the devastating air-raids expected from the first day of hostilities. In this frame of mind I undertook the most expensive taxi journey of my life—to Orpington Hospital—and was not a little surprised, on reaching the town, to be told, 'There's the hospital at Farnborough, and then there's the Institution, but, of course, it couldn't be *that* you were wanting.' At last I found a number of my fellow-dressers sitting on packing-cases in the car park wondering what to do next. Someone would probably tell us before the raids began at nightfall, and eventually we were billeted in neighbouring houses. No raids came, and I might say I have often wondered since just what would have happened if they had.

"The next morning saw us, complete with gas-mask in cardboard box, at the hospital gate again willing to do anything. We piled sandbags outside the Boundary House bay window lest a stray splinter of bomb, entering the Group Office, might disorganise the whole sector; we walked up the hill to the wards and helped to put up a paper black-out; and some of us even helped to clean a gas stove or two. It slowly dawned upon us that the hospital just did not exist; it was a series of empty huts and a number of people of goodwill."

The number of Guy's nurses in these early days were about sixty—about the same number as the K.C.C. assistant nurses already here nursing the chronic sick—as well as from thirty to forty massage students working as nursing auxiliaries. Sister Evans, Head of the Guy's Massage School, was put in charge of the Guy's unit and had to face many difficulties. To solve the lack of accommodation the K.C.C. nurses shared their single rooms and the rooms thus vacated were occupied by pairs of Guy's nurses. Billets were found for the remainder. These conditions, of all except a few of the most senior nurses sharing rooms that were meant for one, still continue, and the nurses deserve the greatest credit for this contribution to the war effort without which it would have been quite impossible to nurse so many patients at Orpington. Meanwhile, in addition to preparing the empty wards, most of the nurses were nursing in the chronic wards, meeting a type of work that was most important but quite foreign to them.

I should like to add what I wrote for the first number of the magazine, written by and for the soldiers in the hospital in 1943 : " Those who come as patients now may be interested to hear something of the buildings before the war and of the start of the hospital in September, 1939. Most of the huts were put up as the Canadian War Hospital in 1916 and a large proportion of the Canadian sick and wounded of the last war were dealt with here. The arms of a Canadian province with the motto " *Ut incepit, sic permanet fidelis* " are still over the stage, and the connection is still remembered, as we have had visits from the Canadian British Legion and from Canadians who were in here as patients.

" After the war it became one of the Ministry of Pension's hospitals, but the need for this gradually diminished. About 1935 the buildings were taken over by the K.C.C. as an institution for the elderly and infirm. For about a year part of the buildings were used as an R.A.F. training centre, and there was a large parade ground where houses now stand west of the hospital. When the hut in which the doctors live was taken over, there were still many R.A.F. notices indicating a miniature range and the Sergeants' Mess. The number of old people grew very rapidly and, at the beginning of the War, there were 775 in the Old Block, under the care of Mr. Dowers, who had come in 1937, and Dr. P. Johnson, who, with Mr. Sales, the hospital engineer, had been here since the days of the Ministry of Pensions. There were no surgical facilities and all patients needing this were transferred to Farnborough.

" Early in 1939, when plans were made for possible war, it was decided to convert this into a hospital and to extend it greatly by building the New Block and by reducing the number of old patients here, so that more of the Old Block would also be available as an E.M.S. hospital."

On the surface little else happened during September, but the Guy's medical staff who had been attached paid some visits and tried to see what could be done. On September 25th I was appointed Medical Superintendent, and remember that for some time I carried all the office equipment with me in a small bag and did such work as could be done from one of the ward side-rooms. By the end of the month Scott and I were living in Orpington and having our midday meal in the Nurses' Home, and Mrs. Epps had been appointed the first Medical Superintendent's secretary. Early in October Kilpatrick joined us—he must have unhappy memories of the anount of time he spent in checking ander checking instruments and inventories—and McNair, Boland, Batchelor and he helped in making our first plans. On October 7th Doherty arrived (after a seven-mile bicycle ride), and our first convoy was detailed in the following document :—

From The Casualty Bureau Officer, Sector X. Date 7.10.39.

CONFIRMATION OF TELEPHONE MESSAGE REGARDING TRANSFER OF PATIENTS

The Group Officer has ordered the transferof the undermentioned 17 cases :—

From Lewisham Hospital to Orpington Hospital

On Tuesday, October 10th

Specification of Cases.—Civilian sick : Medical 9 male (Ward1. H.P., Reeve)
8 female (Ward 2. H.P., Carter)

By now we had our first four house officers—these two and Epps and Bell—but still no accommodation for resident medical staff.

A converted theatre was being made out of the old men's bathroom. One cannot mention the theatre without recalling Sister Smith, who was with us from the start ; her cheerfulness and willingness to help in any direction, whether it had to do with theatre work or not, were unending. In spite of its obvious structural defects it has proved a most successful theatre, though stuffy in hot weather owing to the tons of

mud and sand protecting it from the effects of enemy attack. Considering how much the supporting structures sank under this weight in the early months, it has been a great surprise to find how it has still lasted. Incidentally, I believe that 146,000 sandbags were used in protecting the hospital in this period and that wages bill for this work alone was over £1000.

By October 19th the theatre and sterilising plant were ready for the first operation, but after Scott had waited all this time to give an anæsthetic, the deed was done under a local. On the last day of the month Sister Marriort arrived as Deputy Matron.

In November, thirty men of the 303 London Welsh A.A. battery were admitted one afternoon with acute food poisoning. For the first few hours several of them seemed desperately ill—almost reminiscent of cases of cholera—but within a few hours the worst were obviously out of danger and would not have been with us long if they had not kept the ward in quarantine till Christmas with a slow epidemic of scarlet fever. The great changes since then are brought home by remembering that these men, when convalescent, played football in the field in pyjamas and blankets, as their uniforms had been taken away for disinfection and they had no second uniforms or hospital blues ! This led to some pleasnt return visits and dances in their beautiful old quarters at Wickham Court.

In December authority was given for the appointment of our first whole-time dispenser, and Mr. Roderick has been with us every since. In a small crowded room, looking little like a hospital dispensary, he has got through an enormous amount of work dispensing more than 10,000 mixtures a year and a larger number of stock medicines, pills, tablets, etc. ; and he has always been ready to do more.

About this time the massage students ceased to be nursing auxiliaries and returned to their normal work, and Sister Evans found a house in Orpington for their school. Cycling to and fro they soon became a well-known and popular feature of the town and were a great help with the work when the Orthopædic Department developed. Our E.M.S. patients gradually increased to about 100, and we felt that with ninety operations performed—about a week's work in 1941–45—a start had been made in preparing for our surgical work. I might add that at this time and subsequently all through the war about 600 of the old chronic patients have remained with us—not always the same for with so many over ninety they cannot live for ever.

And so the year came to an end with the massage school pantomime " Dick Orpington," who, being knocked down in the street by a massage student on her bicycle, was brought to hospital and dreamt a dream while under the anæsthetic—memorable not only for its intrinsic merits, but for being the only occasion when the medical staff displayed their histrionic ability.

The new year saw several changes in personnel. In December all the senior E.M.S. staff, except Scott and myself, went on to part-time ; and, in January, Lindsay Locke came as radiologist, and R. A. Johnson, as our first Medical Officer. He had been in dental practice, and it was said that when I put him in charge of a medical ward he first went round with Sister to get the diagnoses and then, having studied a text-book, returned to arrange their treatment. With such an outlook he became a most useful all-round member of the staff : his manual dexterity helped him in the orthopædic work, and he had a valuable gift of giving an accurate orthopædic prognosis. He remained with us till August, 1944.

On February 1st J. T. Laurenson arrived as our whole-time surgeon. It was an anxious moment, for no one had seen him or knew anything about him and my caution made me think that there must be something wrong with any New Zealander who had been doing post-graduate work in England so long. However, we all took to him at sight and our first impressions have been fully borne out. He has shown us all what the ex-general-practitioner surgeon can be like at his best, and more uniquely his cheerfulness and humour pervade the whole hospital so that it seems a less living place when he is away. No one can ever have made more rude remarks to more people without giving offence.

In early 1940 work was gradually increasing, and in January we had our worst epidemic of influenza and German measles and two wards filled with patients with very few nurses to look after them. Except for this and the earlier scarlet fever and true influenza among the nurses in 1943 the hospital has been singularly free from widespread epidemics. Considering the number admitted with infections and not transferred to fever hospitals, I think that our relative immunity must be attributed to the

isolation of the huts and the open air between, and that this is one of the real advantages of a hutted hospital.

During the first six months the relatively light medical work did not mean that the senior staff had little to do. When I first came the concrete foundations for the new huts were just starting, but there was nothing above ground. A fine block of thirteen more wards and a theatre gradually appeared, but there were, of course, many problems, where changes were wanted and where details of kitchens, cupboards, fittings, theatres and X-rays rooms had to be decided, the final authority being often difficult to reach. Many of the things we fought for were obtained sooner or later. All this building work must have been one of the reasons why memories of the first winter are of so much mud and rain—we went everywhere in Wellingtons—but the dismal sound caused by the constant dripping of rain on the roofs of the huts will not be forgotten by those who have lived in them.

Apart from the new huts there were many other administrative problems, quarters for the medical staff, more accommodation for the nurses (a problem that has not yet been solved in spite of what has been done), the protection of the hospital and shelters, and many others. At a large established hospital everything being available at a moment's notice is almost taken for granted, but until they have had to provide it from nothing, no one can have any idea of the complexity of the task and how much hard work behind the scenes is needed—in laboratories, in kitchens, in laundries, and in offices and elsewhere—to produce the smooth running of the wards and theatres. Here, under war-time conditions with divided responsibility, it sometimes seemed as if progress was impossible.

Familiar with the working of voluntary hospitals and remembering something of the direct, even if slow, methods of Army routine, the complex machinery and the Ministry of Health, the Group Office, and the County Council seemed to me a cumbrous one, especially for war-time. I was impatient for the hospital to be ready for the demands that might be made on it and my complaints culminated in a long interview with the Director-General E.M.S. in February, and a visit from the Parliamentary Medical Committee in March.

These and later experiences have taught me much of English local government and its relationship with the Ministries of the central govern,ent—factors which have a vital influence in the proposal for the new National Health Service. Now that many contacts and friendships with officials—central and local—have given me chances to discuss these problems, I feel that it will be very difficult for public services to reach the standard of the best voluntary services—whether hospitals or schools or other bodies—unless Parliament can find a solution to the problem of a real degree of local autonomy wth an adequate but flexible central control. These difficulties in many detailed and practical forms, if not in such theoretical guise, occupied much of my work and of all our thoughts in the early months. Looking back, it seems that the Ministry should have worked out the scheme in more detail. The K.C.C. had their own work to do with a depleted staff; Guy's were under the impression that they were coming to run a hospital provided by the Ministry. Under such conditions difficulties were inevitable, and it seems creditable to all that such good work should be done when the time came.

From January onwards I had been anxious to get some patients into the new huts to test them in working order, but the last adjustments and water and electricity, telephones and equipment all caused delay, and it was not till March 26th that two wards could be opened. As the wards of the Old Block were numbered, those of the New Block were named, but in alphabetical order so that they could be easily placed—Addison, Bright, Christopher, Dorcas, Evelyn, Fagge, Thoms Guy (operatlng theatre), Hunt (subsequently the department of physiotherapy), John, Keats, Lister, Mary, Nuffield and Osler—names reminiscent of Guy's except that a great physician and a still greater surgeon were added.

At this time convoys of soldiers (mostly sick and accidents) were arriving from the military hospitals in France. On April 16th I was able to report that I could receive such a convoy of up to 300 patients and was told that one would soon arrive. We had at that time about 150 patients including about 20 soldiers, so it meant a sudden change. The next day Major Philpott arrived, unheralded, as Medical Registrar, with some R.A.M.C. personnel, and by the evening Mr. Dowers had fitted them up

with an orderly room and a large pack store (a relic of the last war). On April 21st the following telegram was received :—

248 B 3.22 Southampton OHMS.

Priority Orpington Emergency Hospital Kent. Ambulance train 55 despatched 1505 approx arrival 1821 other ranks surgical lying twenty-three sitting thirty-seven medical lying forty-two sitting seventy-three mental lying two sitting fourteen T.B. lying seven sitting two spec fractures lying nine sitting six. A. D. M. S. (A).

What followed I should like to quote from the Orpington letter that appeared in the *Gazette* —

" Shortly before 6.30 one beautiful Sunday evening a man was walking hastily to and fro among a host of officials and people gathered in Orpington Station, giving his last-minute instructions. He was not above medium height but of goodly proportions, his hands were full of impressive diagrams and complicated lists, and his puckered brow betrayed the heavy responsibility he was bearing. All around him were men and women in the uniforms of the Red Cross and St. John's Ambulance waiting beside their stretchers ; outside the whole strength of the local A.R.P. personnel and transport were collected in impressive numbers, while beyond the population of Orpington were gathering in ever-increasing numbers. Suddenly the station bell began to sound, a herald of the train which appeared a few minutes later—a train whose green coaches had red crosses on their sides. And, as it drew into the platform, the first B.E.F. convoy for Sector 10 had arrived at the last stage of its journey to Orpington War Hospital.

" The removal of the soldiers from station to hospital occurred with amazing speed and efficiency, thanks to the foresight of Dr. Scott, who had spent so much time in perfecting the details of their transport, while their distribution through the wards proceeded with an ease which we have come to expect of Dr. Campbell. So it was not long before they had all been tucked up in bed, and when lights went out that night, there were nearly two hundred more beds occupied than on the previous night."

Three days later the medical staff were able to move into their quarters in Hut 33 and the first residents were the five house-officers who were joined by Scott early in June.

This convoy gave us our first impression of military medicine. The surgical and accident cases were as might be expected, and, on the whole, seemed to have been treated well overseas—a view that has lasted all through the war. The large medical groups were tuberculosis, emphysema, and peptic ulcers ; this last, giving another true forecast of conditions all through this war though in my memory of the last war, when X-rays were little used medically, it was not a serious problem. One of the most interesting things to a physician was the number of men with emphysema. They were reservists of about forty who were all right in civilian life when they could carry on at their own pace, but very dyspnœic when they had to work faster with others who were younger. In most of them the emphysema seemed to precede any significant degree of bronchitis.

To deal with this expansion we had been reinforced by Vertue as whole-time, and by Hale-White as part-time, physicians, by Roberts as J.M.O., and by several sisters who were to stay a long time. Sister Hilda Gratian, senior Sister Tutor at Guy's, came to organise the teaching of the nurses and has been with us ever since. The Matron writes that, in spite of the difficulties of very limited accommodation, the theoretical teaching of the nurses has never suffered ; that it is the acute medical and the acute surgical work that has been short at Orpington ; and that the theatre experience has been especially good for the nurses, owing to the absence of medical students. Sister Gratian's book, " The Practice of Nursing " (Faber and Faber, 1944) was written and published from Orpington (and it is perhaps worthy of mention that five of the first six volumes of the *British Heart Journal* were also published from Orpington).

Another arrival was Sister M. Griffith, and her devoted and tireless work in Ward 5, which was set aside for the R.A.F., with a section for officers, made it one of the best known and most popular parts of the hospital. Officers and men in many parts of the world will remember her unfailing care and kindness and her skill in cooking. Sister Pratt was in charge of Ward 1 (mixed medical and surgical) and had a heavy responsibility which she discharged with perfect efficiency, as it was the main take-in ward for male air-raid casualties and accidents at night. From a rather later period Sister Benson carried out the same work for the women on the other side of the corridor.

Soon after this the X-ray department in the New Block became available. Sister Randles had been here since the start and, in addition to the difficult task of organising the School of Radiography in new surroundings, acted as radiographer and also gave much general help. Miss Barwell has also been here throughout the war, and for long periods Sister Looker, and later Miss Kyte, were in charge in the New Block. This department has got through a large amount of work, and in addtion, Sister Randles has conducted a large part of the school work here for most of the war period.

On May 10th, 1940, the following notice was posted in the hospital:—"All E.M.S. staff will remain on duty, leave having been cancelled till further notice. Order received from the Group Officer." Germany had invaded Holland and Belgium and the War had entered on a new phase. As Fagge ward has perhaps dealt with more orthopædic casualties from overseas than any other ward, it is an interesting coincidence that it was first opened on this day, with Sister Gale in charge to help in establishing the best orthopædic traditions.

But for some time the stirring and historic events in France had no direct effect on Orpington. We shall all remember the wonderful May weather, with sun and cloudless skies, almost emphasising the bad news. On May 31st we were told to expect wounded and, just before midnight, a convoy of thirty-six arrived. Some had been wounded for three days, and many had been in the water for hours. One, who had been in the Channel with both legs broken, had to have a double amputation, but made a good recovery. Another had had an abdominal operation by a French surgeon in a wood in France, and had been carried miles in a farm-cart and on a stretcher before getting on a boat; he, too, did well finally.

As in many other hospitals burns were prominent among the injuries, and the blackened faces and hands added to our vivid impressions of that long night. The new theatre, which had been little used, was in demand all night. The medical treatment which the men had received was surprisingly good considering the difficult conditions. Generally it was well done with orthodox splints, but one man arrived with his fractured leg still splinted in a first-aid broken-up Tate sugar box, showing how much nearer we had got to acting as an Advanced Dressing Station than we had ever expected. After the first night our news of further arrivals was, not unnaturally under the conditions, most erratic. Sometimes we were told to expect a convoy and waited all night for nothing. Sometimes the warning was very short or absent. On June 1st we received a few more casualties and on June 3rd a final sixty; but others, who had already been in some hospital at the coast or in between, arrived during the next weeks, so that at the end of July we still had more than one hundred with us.

It was a busy period for all the hospitals in Sector X, as this covered most of the area radiating from London towards the coast and included much of Kent. One of my outstanding impressions is how well the medical officers on the ships and at the coast, had decided which patients could stand the further journey here and which should be kept in the coast hospitals. In spite of the appalling military disaster there had been in France. we were all struck by the attitude of the wounded who arrived here as there was none of the spirit of a defeated army, and the men's cheerfulness was, of course, a great help in getting good results in their treatment.

One unexpected problem was the arrival of about seventy French soldiers, including many French colonial troops; few of them could speak any English, and two or three could speak no French, so that communications had to be through another patient who could speak both French and their African languages. I was surprised at the number of doctors and nurses in the hospital who were able to talk to them in French, and equally surprised to find how slow many of the patients were to learn any English. Gradually most of them were taken away to convalescent depots, etc., but a few of them were with us for many months and grew to look on the hospital as their home. Most of those who recovered joined the Free French Forces.

Looking back at the period from May 10th to June 1st, even as reflected in one hospital so far from the centre of these events, one is more and more impressed by the crisis through which Britain was passing and by the normal and matter-of-fact way in which it was faced by everyone. So far, except for the one busy week, we felt that our task had been mainly preparation. The next stage of the story found the hospital much nearer to the focus, for the Battle of France was over and the Battle of Britain was soon to begin.

(To be continued.)

HEIDBRINK - FOR ANAESTHESIA

Reviews

A Companion to Manuals of Practical Anatomy. By E. B. JAMIESON, M.D. 6th Edition. Oxford University Press. *Price* 16*s.*

THE purpose of this volume, as stated in the preface, is " to provide, in an easily portable form, an account of naked-eye Anatomy . . . ." This purpose is adequately fulfilled—but for whom is the book intended? For the student learning his anatomy or for the revision student? It may be stated that it is of little—even detrimental—value to the former, but to the latter its value is considerable.

The book is divided into sections which are headed systematically, the text itself being clear, concise and accurate. The arrangement, however, leaves a little to be desired. In the fifth edition a general change-over was made from a systematic to a regional arrangement. Yet this change does not appear to have gone quite far enough, and were it not for the excellent index much difficulty would be experienced in finding references—*e.g.*, the brachial plexus is described in three separate parts, causing also some repetition of the text.

The subject-matter itself is very complete, this completeness being partly attained by the use of abbreviations which do not, however, detract from the readability. The completeness of the descriptions of the relations of structures is particularly commendable, these relations being so important, yet so often " overlooked " by the student.

This book is a useful asset to the revision student who is prepared to read it slowly and carefully, and to confirm the statements contained therein by constant reference to a specimen or to a part actually under dissection. M. W. J. G.

A Class Book of Practical Embryology for Medical Students. By P. N. B. ODGERS. Oxford University Press. 1945. 63 pp. with 30 figures. *Price* 7*s.* 6*d.*

THIS little book is essentially a practical class-book for use in medical schools and universities where the study of the embryology of the pig is utilised to supplement (or replace) the study of human embryology. The figures are clear and well chosen, and the letterpress, though limited in amount, is adequate for its purpose. T. B. J.

Modern Treatment Year Book, 1945. Edited by CECIL P. G. WAKELEY, C.B., D.Sc., F.R.C.S. Pp. 300+viii, 60 illustrations, including 15 plates. Medical Press and Circular. *Price* 15*s.*

THE purpose of this collection of forty-five short papers on medical, surgical and gynæcological subjects is to provide a summary of modern methods of diagnosis and treatment for the general practitioner. Unfortunately no effort seems to have been made to select topics of general interest, or to present a picture of the more significant advances made during the last few years. Some of the articles are out of date for a year-book published in 1945. For example, the paper on the treatment of meningitis makes no mention of penicillin, while the important and controversial question of thiouracil is given but one page of the author's personal views, without reference to the extensive literature on the subject.

With a few exceptions, such as Barnett's paper on hydatid disease and Manson-Bahr's review of the treatment of malaria, this volume contains the same type of information as the standard text-books. P. F.

A Handbook on Diseases of Children. By BRUCE WILLIAMSON, M.D., F.R.C.P. Pp. 368. E. and S. Livingstone. *Price* 12*s.* 6*d.*

THIS handbook, first published in 1933, now appears in its fourth edition, a fact that testifies to its popularity. The new edition differs little from the last, though the text has been revised and new sections on the Rh. factor and penicillin have been added. The former of these is ingeniously done, giving an excellent summary. The latter, owing to the nature of the subject dealt with, and not to any fault of the author, is hopelessly out of date. N. M. J.

Sport

Rugby

GUY'S *v.* HARLEQUINS.
(*At Twickenham, Saturday, January 12th.*)
Result: Guy's, 10 points; Harlequins, 8 points.

Guy's continued their run of successes against the "Big Five" when Harlequins were defeated at the Rugby Union Ground, Twickenham, by 2 goals to a goal and a try. This result was most satisfactory as we had previously added Rosslyn Park and Richmond —Blackheath to our list of victims. The pity of it all is that we do not play London Scottish this season, and it may be a long time before we meet the Harlequins again, as they refuse to give us a fixture next season.

One Sunday newspaper reporter stated that "the result was not a true reflection of the play." If he means that Guy's did not deserve to win it is a view to which the writer cannot subscribe. It is true that the Harlequins were attacking for the greater part of the second half, but if a side does not possess the skill to turn their numerous opportunities to account then it does not deserve to win. The Guy's defence was a repetition of the South African match, and the forwards deserve most of the credit for the magnificent way in which they forced the Harlequins to part with the ball and finally broke up all their passing movemente by deadly tackling.

The Hospital started against the wind as if they were in for a big score. Within five minutes Van der Westhuizen took a neat pass from Dwyer to cut through for a try which Lewis converted, but the Harlequins quickly reduced the lead with a try by C. H. Watson following a good bout of passing. Guy's continued to have the better of the first half, but the three-quarter line was not working at all smoothly, most of their attacks being of an individual nature.

The Harlequins endeavoured to make it a forward game in the second half and succeeded by sheer weight in pushing our lighter pack many yards, and it was this superior weight that enabled them to get the ball from most of the scrums. Early in this half the Harlequins gained a fortunate try when C. H. Watson ran hard for the corner and, on being tackled by Gray, knocked over the corner flag. The referee however, without hesitation, awarded a try which K. H. Chapman converted from the touchline.

The Hospital backs only occasionally obtained the ball and still persisted in individual play with kicks ahead, and it was from one of these that Gray dribbled over and touched down for a try, which Lewis converted in almost the last minute.

Something has gone wrong with our three-quarters. The passing was often too hurried and, although Owen and Van der Westhuizen broke away skilfully on occasions, they failed to bring their wings into the movement, and once again Macrae-Gibson had few chances in attack. It might also be a good thing if Dwyer, whose defensive play is very sound, endeavoured to break through more often, thus giving the three-quarters more room in which to initiate their attacks.

Association

GUY'S *v.* BIRMINGHAM UNIVERSITY.
(*At H.O.P. on Saturday, December 5th,* 1945.)
Result: Lost 1–4.

The match with Birmingham University was a new fixture for Guy's and, consequently, we knew very little about the strength of our opponents. The fact that this same Birmingham team had previously beaten Cambridge University forewarned us that our task would not be easy.

However, Guy's settled down very quickly and had the Birmingham team completely on the defensive. In these first few minutes Sykes, Leckie and Evans all went very near to scoring. After ten minutes' play, however, Guy's suffered a great misfortune when Matthews severely injured his right ankle and had to be carried off. With only ten players the Guy's team was naturally weakened but, nevertheless, Trist and Munro did splendid work on the right wing and were always dangerous.

Birmingham scored twice in the latter part of the first half, both goals being "made" by a fine left wing.

Soon after the interval Leckie scored for Guy's with a grand shot from 25 yards. This stimulated the Guy's team to even greater efforts but, with only four forwards, it was found impossible to penetrate a sound defence. Towards the end of the game Birmingham scored two more goals, one of which was from a penalty.

In conclusion, one must congratulate the whole team for a fine performance in very trying circumstances.

Team.—I. L. Busbridge; C. S. Matthews, R. A. C. Dove; M. J. L. Sykes (captain) H. R. C. Riches, W. A. Evans; I. H. Munro, A. E. Trist, J. C. Leckie, R. K. Foster, A. R. Merril.

Hospital Information, etc.

Notices

CLUBS' UNION.—PHYSICAL SOCIETY.
(FOUNDED 1830.)

A meeting will be held in the Physiological Theatre on Monday, February 4th, 1946, at 5.30 p.m., when Dr. Maurice Campbell will speak on the history of the society.

All members of the Clubs' Union are invited to attend, and it is hoped that a Committee will be elected to revive the Society.

A Clinical Lecture will be given by Professor J. A. Ryle, M.D., F.R.C.P., Professor of Social Medicine, Oxford University, on Thursday, February 28th, 1946, at 1 p.m., in the Physiological Theatre. Subject: "Social Pathology."

Applications are invited from ex-Service men and other candidates for the post of Junior Resident Anæsthetist, duties to commence as soon as possible. Salary: £200 per annum with full residential emoluments.

Applications should be lodged with the Superintendent, Guy's Hospital, S.E.1, immediately.

Pass List

CONJOINT BOARD.

December, 1945.

Chemistry.

C. B. Bowes	H. L. Scott
L. P. Frank	W. R. Thomas
E. D. Morgan	P. A. Van der Merwe
H. A. H. Ohlrich	N. J. Wood

Physics.

W. A. B. Brown	D. H. M. C. Romans
G. L. Moore	F. H. Walker
S. Morgan	N. J. Wood

Elementary Biology.

W. A. B. Brown	S. Morgan
W. F. Dobson	F. H. Walker
L. P. Frank	

FIRST AND SECOND PROFESSIONAL EXAMINATION.

L.D.S.

December, 1945.

Dental Metallurgy.

R. D. Baker	M. J. Smallcombe
D. G. Brett	A. H. Stocker
V. H. Freiberger	R. E. B. Turner
G. D. Richards	

Dental Mechanics.

L. Becker	C. B. Palmer
B. Engelsman	M. P. O'Reilly
H. L. Lefcovitch	

Anatomy and Physiology.

P. J. Attenborough	G. G. Phillips
R. C. Curties	B. S. Saunders
D. J. W. Foster	W. G. Selley
B. M. Gray	K. S. Sunaway
G. Holding	R. D. F. Thiel
M. B. Lacey	G. P. J. Williams
N. E. McIntyre	P. J. F. Woodroof

Special Anatomy and Physiology.

T. L. Barker	E. T. Hunt

UNIVERSITY OF LONDON.

FIRST EXAMINATION FOR MEDICAL DEGREES.

(For External Students.)

December, 1945.

D. R. Boswell	B. E. Lawson

FIRST EXAMINATION FOR MEDICAL DEGREES.

(For Internal Students.)

December, 1945.

D. G. E. Alldridge	A. L. Giulianotti
G. P. Billingham	J. M. Holden
D. F. C. Deacon	D. H. Hutchings
G. R. C. Deacon	P. J. A. Lawrence
D. B. Evans	D. Lennie
A. T. T. Forrester	I. H. Maine
P. Glazebrook	F. H. Walker

The following Students have completed the External Examination :—

T. S. Hart	K. E. MacLachlan
J. V. Jeffs	A. M. Reader
M. Kaye	P. S. B. Russell
M. M. Keen	A. V. Watts

Change of Address

A. P. Dale-Bussell, M.B., B.S., The Cottage, Warren Hill, Newmarket.

J. K. Donald, L.D.S., R.C.S., Hursley, Poole Road, Bournemoth.

H. E. Filmer, M.R.C.S., L.R.C.P., St. George's Park House, Great Yarmouth.

J. R. Forbes, M.D., M.R.C.P., Guy's Hospital, London, S.E.1.

R. C. Green, Captain, A.D. Corps, 184th Mobile Dental Unit, B.T.A., C.M.F.

H. C. Muirhead, M.R.C.S., L.R.C.P., 70, Upper Hanover Street, Sheffield.

A. M. McCall, Surg.-Lt.-Comdr., R.N.V.R., 14, Warwick Park, Tunbridge Wells, Kent.

R. H. F. Pearce, L.D.S., R.C.S., Broadhurst, Alexander Road, South Farnborough, Hants

J. H. Smart, S/Ldr. R.A.F., 10th R.A.F. General Hospital, Karachi, S.E.A.A.F.

A. R. Thompson, M.R.C.S., B.D.S., 40, Harley Street, W.1. (Tel. : Langham 2720.)

J. A. S. Wright, L.D.S., R.C.S., 27, Wimpole Street, W.1. (Tel. : Langham 1833.)

W. M. Wylde, L.D.S., R.C.S., 18B, Bushmead Avenue, Bedford.

New Year Honours

O.B.E. (Military).

Actg. Sqdr.-Ldr. W. L. James, R.A.F.V.R.

O.B.E. (Civil).

Leslie George Housden, M.D.

M.B.E.

Major J. B. Hardie, A.D. Corps.
Major E. D. Stanhope, A.D. Corps.
Sqdr.-Ldr. L. C. Bellsham-Revell, R.A.F.(D)

Mentioned in Dispatches.

Wing-Cmdr. R. C. Jackson, A.F.C., R.A.F.O.
Sqdr.-Ldr. F. R. Buckler, R.A.F.V.R.
Flt.-Lt. G. E. McFall, R.A.F.V.R.
Group-Capt. F. F. Kennedy, R.A.F. (D.).
Sqdr.-Ldr. J. A. R. Smit, R.A.F. (D.).
Flt.-Lt. C. A. W. Archer, R.A.F. (D.).

Knight of the Order of St. John of Jerusalem.

Lieut.-Gen. J. B. Hance, C.I.E., O.B.E., K.H.S., I.M.S.

Serving Brother of the Order of St. John of Jerusalem.

Dr. J. S. Cooper.

Roll of Honour

SECOND LIST.

Major Richmond Edwards, R.A.M.C., Missing November, 1943, and later presumed lost at sea.

Nursing Staff.

Miss Norah C. Holroyde. Killed by enemy action.

Miss M. J. Livingstone. Missing ; later presumed lost at sea.

Miss Joan Pitt. Missing December, 1942, and later presumed lost at sea.

The Services

Mentioned in Dispatches.

In recognition of gallant and distinguished services in Burma :—

Lt.-Col. (Temp.) L. H. Cooper, I.M.S.
Capt. B. Rowlatt, I.M.S.

The undermentioned have also been mentioned for services in various theatres of war:

Actg. Major D. A. Parsons, A.D. Corps.
Capt. R. J. G. Grewcock, A.D. Corps.
Capt. W. L. Trick, A.D. Corps.

Births

WILSON.—On January 16th, 1946, at 8, Old Castle Road, Salisbury, to Mary (née Rooker Roberts), wife of Colin W. Wilson, Surg.-Lieut., R.N.V.R.—a daughter, sister for Patch and Angas.

Marriages

CURLETT—JONES. — On January 10th, 1946, at Methodist Church, New Malden, Surrey, William Fulton Curlett, of Ballywalter, North Ireland, to Nora Janet, eldest daughter of Mrs. M. Jones, 32, Blakes Lane, New Malden, Surrey.

Deaths

GREEN.—On January 26th, 1946, at St. Leonards-on-Sea, Albert Green, M.B., for over thirty years H.M. Coroner for North-East Derbyshire, aged eighty-five.

PADBURY.—On January 25th, 1946, George John Padbury, M.B., of Axminster, in his eighty-fifth year.

EDS. {J.M.H. R.H.N.L.

GUY'S HOSPITAL GAZETTE

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RECENTLY a clinical demonstration, the first of its kind since the "Combined Rounds" of the late Sir Arthur Hurst, was held in the Pre-clinical Classroom. A series of cases were demonstrated and some members of the staff were present to furnish a pathological background to each. We note with pleasure that it is intended to continue this scheme into the future with further demonstrations at fairly frequent intervals; may we express the hope, however, that these sessions will continue on the same level as the first and not deteriorate with the passage of time when the initial novelty has worn off.

Whilst we realise the value to the student of personal clinical examination of patients, we would suggest that, if everyone present examines the case, time is wasted and could be better spent on discussion. It is a simple matter for anyone sufficiently interested in a case, to follow it up and make a subsequent examination in the wards.

In the days of Sir Arthur, it was traditional that the ward clerk to whom the case in question was allotted, presented the case history together with his account of the clinical findings. This supplied the clerk with beneficial—if somewhat harrowing—additional experience. The first of the new series of demonstrations, however, impresses upon us the advantage to the audience, at least of a more concise and pertinent account of the patient's story, over the unavoidably lengthy and sometimes muddled history delivered by the harrassed clerk.

WE have been asked to announce, in connection with the Will Edmonds Clinical Research Fund, that applications are invited for a Fellowship of the value of £500 a year, to be awarded for clinical research in hospitals in the Metropolitan area of London. This research must concern diseases such as are usually treated at a general hospital (tropical and rare diseases being excluded). Candidates for the Fellowship must be duly qualified and registered medical practitioners. The Fellow appointed should be a whole-time worker on research or academic duties and should not be engaged in private practice. Applicants should state their qualifications, the line of research they wish to pursue and the hospital in which they propose to carry out the research. Further details may be obtained from the Secretary of the Fund, the Assistant Secretary, The Royal College of Physicians, Pall Mall East, London, S.W.1, by whom applications for the Fellowship, giving the names of two referees, must be received not later than June 8th, 1946.

ON Friday, February 22nd, at 4.30 p.m., in the Physiology Theatre, a combined meeting of the Students' Union and the Music Club will be addressed by Dr. R. Vaughan-Williams, O.M. His subject will be "Making Your Own Music." All members of the Hospital are Welcome.

IT is with regret that we learn of the departure of Miss E. A. Purcell, Sister-in-Charge of York Clinic since its inception, to take up the duties of Matron of the West Park Hospital, Epsom. We take this opportunity of extending to her our very best wishes for the future.

MR. W. A. DAY has retired from the Works Department after an association with the hospital of 47 years; we have lost also two of our Porters, Mr. G. Butcher and Mr. A. J. Mills, who have retired after 25½ and 25 years' service respectively. We offer them the thanks of Guy's and wish them many happy years in retirement.

WE would remind our readers that the annual subscription to the *Gazette* and "Directory of Guy's Men (Medical and Dental)," 12*s.* 6*d.* per annum, post free, is now due and should be forwarded to the Manager, the *Gazette* Office, Guy's Hospital, S.E.1. We hope that the new "Directory of Guy's Men" will be published by Easter and, when ready for distribution, it will be sent to all subscribers.

Cancer of the Rectum

A Clinical Lecture delivered at Guy's Hospital on Thursday, January 24th, 1946, by N. L. ECKHOFF, M.S., F.R.C.S.

GENTLEMEN,—I often quote the story of the patient sent to me with the note "this man has been passing blood and slime for nine months. I think he needs a rectal examination." He certainly did.

A year ago, another doctor was horrified to hear that his patient had a rectal carcinoma, since a barium enema revealed nothing. (As a matter of fact, the carcinoma was so far advanced that it *did* produce distortion of the rectum in the X-ray, but who would think of expecting the radiologist to exclude rectal cancer ?). In yet another case, the patient had seen an eminent Middle European physician and an eminent urologist only six weeks before, yet large grape-like masses were being passed per rectum from his carcinoma. It is clear that these three cases could have been saved from becoming inoperable by a timely rectal examination which, I hope, no Guy's man would forget to make.

I must mention one Guy's man who suspected a carcinoma—did a rectal examination and felt nothing abnormal; but he had the good sense to seek a second opinion, and a very early carcinoma was found in the ampullary portion of the rectum.

I have at this moment no less than five cases of rectal carcinoma in my ward at Guy's, and three of pelvirectal carcinoma elsewhere, and I thought it would be useful to consider the lessons of these cases today.

Diagnosis.—The diagnosis is essentially simple. Alteration in bowel habit—usually frequent calls to stool with little result (tenesmus), sometimes constipation, passage of blood and later mucus—demands a rectal examination. In one of the recent cases, injections had been made for piles, but the carcinoma missed. In another diagnosis was delayed because the doctor considered that freedom of bowel action indicated that no tumour was present. Beware of this illusion. Cancer of the pelvic colon or pelvirectal junction certainly produces obstruction, but even this is remarkably silent at times. The rectum is so wide that a cancer may be present for a long long time before constipation is marked. But either a rectal carcinoma or a pelvirectal carcinoma frequently produces spurious diarrhœa, owing to the great secretion of mucus stimulated by the growth, and above it from irritation. "Alternating constipation and diarrhœa" is another misnomer. It is more correctly a gradually increasing *constipation with gradually increasing spurious diarrhœa and tenesmus.* You will note that I have said little about pain. Pain is a symptom of most surgical complaints, and the layman unfortunately thinks that a painless disease is not dangerous, and defers advice. But pain in rectal cancer usually means invasion of the surrounding structures and a degree of advancement that often precludes surgical extirpation.

Rectal examination.—There is nothing particularly difficult about this procedure provided one is gentle and takes sufficient care. The finger is well lubricated (I prefer a tragacanth lubricant to vaseline, for it washes off so much easier) and the anal region palpated to exclude painful conditions here, and to assess the tone of the sphincter. Anal spasm may demand an anæsthetic. If there is no anal spasm the finger is slowly introduced. If a tumour is easily found its edges are palpated very gently, and one can usually appreciate with striking vividness the raised everted irregular edge so characteristic of carcinoma. Next an attempt is made to assess the size of the tumour. In an early case it may be possible to sweep the finger round it and determine that it arises from the front or the back wall. In late cases the tumour will have grown round the bowel so that it is impossible to determine its origin or its upper limit, and in such a case the lumen is reduced to a narrow irregular channel. The cauliflower type is not particularly common. It is now necessary to determine the fixity of the tumour, particularly in relation to the sacrum behind or the prostate in front. Such fixity usually makes the growth inoperable. Fixity to the cervix does not necessarily do so—for the uterus (and vagina) can be removed with the rectum.

In the case where no growth is easily palpable special care is needed, and the finger must be swept round the wall of the rectum, not forgetting the ampulla. A bimanual examination—or asking the patient to strain or sit on the finger—may be required to exclude pelvirectal carcinomata. These growths are the ones most frequently

missed, and sometimes can only be felt as hard tumours through the wall of the bowel. If fæces are present it is wise to ask the patient to return again.

X-ray examination.—I have already indicated that X-ray examination has no real place in the diagnosis of rectal carcinoma, for the finger only is required, but it may be helpful in pelvirectal growths. But remember that as the rectum follows the curve of the sacrum and curves forwards towards the examiner, it is not always easy to get a profile view, and one must not rest content with a negative report in the presence of symptoms.

Proctoscopy and Sigmoidoscopy.—It is rarely possible to see a rectal growth through a short proctoscope. Sigmoidoscopy is useful if one is in doubt about a high tumour. It is also useful in determining the presence or absence of multiple polyposis. Three of the cases at present in Queen Ward have multiple polyposis (one familial) and the relationship between polyposis and carcinoma is so close that one has no hesitation in calling the former precancerous. In fact, it is the best example of an innocent tumour becoming malignant that I know. Dukes has found associated adenomata in seventy-five per cent. of cases of rectal carcinoma.

Treatment.—Of the five cases in the ward, one was early (diameter 1½ inches), one a little bigger (diameter 2½ inches), one was so fixed as to be removed with great difficulty, and two were inoperable. The St. Mark's figure for operability is about 60 per cent.

In inoperable cases Colostomy is indicated to relieve symptoms and to relieve impending obstruction. In advanced cases it is naturally not always possible to relieve pain.

There are four methods of resection commonly practised in this country for operable cases :—

1. Perineal excision.
2. Abdomino-perineal excision.
3. Perineo-abdominal excision.
4. Combined operation (two surgeons).

Perineal excision demands a preliminary colostomy. It is not possible to deal so completely with the glandular field and a small loop of bowel remains below the colostomy which may be a nuisance, from mucous fistula or recurrent abscess formation. But the mortality is less (11 per cent. compared with 16 per cent.) and the five year survival rate is fairly good, except for Class C cases (18 per cent. only). It should here be pointed out that Dukes, at St. Mark's Hospital, has greatly assisted the surgeon by the excellent pathological work he has done. Each specimen is opened, stretched on a frame and fixed. It is then photographed, drawn, and carefully measured, and sections are taken from various parts of the rectum and from the glands up the vascular pedicle, and the results carefully charted. As a result he has been able to classify cases thus :—

A Cases where the growth is limited to the rectal wall.

B Cases where the growth has spread through the wall.

C Cases where the regional lymph nodes are involved in addition.

This has an important bearing on prognosis :

Thus the five year survival rate is over 80 per cent. for Class A, but only 30 per cent. for Class C, in the combined operation.

The other three operations are largely similar in extent. It is possible to remove the glandular field at least up to the aortic bifurcation, and the level of colon section can be adjusted to suit the case. The combined operation (two surgeons) is excellent. It is very necessary to have wide lithotomy crutches and a slight Trendelenburg tilt. With two surgeons working together the time of the operation can be drastically reduced, shock-producing changes of position are avoided, and in my opinion the separation of the rectum is much easier, and the closure of the pelvic floor is simple. Blood transfusion during the operation is essential.

Careful preoperative investigation and preparation are explicit, with special attention to cardiac and renal function and possible anæmia. Sulphasuccidine Gms. 20 (40 tablets) daily for five days virtually sterilises the intestinal contents. Sulphanilamide sprayed into the wound at the end of the operation may be redundant, but I have not seen it do any harm. In males a catheter is tied in at the beginning

of the operation (so that one can the more easily identify the urethra) and in females a self retaining catheter is inserted at the end. The perineal wound is packed (oil silk and gauze).

Postoperative treatment.—We must be grateful for all the work done at St. Mark's to lessen the risks to the patient. The catheter is connected up with a Dukes' apparatus, which permits drainage and irrigation without incessant interference, and interposes a water seal between the bladder and the exterior, thus greatly minimising urinary infection. After a few days " tidal drainage " can be added with but little alteration in the apparatus.

The perineal pack is reduced in size in forty-eight hours under basal narcosis, and removed in four to five days.

The end colostomy may be kept clamped for two to three days if the patient is comfortable, but there is no objection to removing the clamp earlier if " gas pains " are present. Some relief may thereby be obtained, but as a certain measure of ileus is inevitable after any abdominal operation, the amount of relief is often disappointing. In fact, it may even be necessary to institute duodenal suction, and its inevitable counterpart—intravenous infusion. It is always my aim to cease intravenous therapy at the earliest possible moment, for there are inevitable dangers. We recently saw pulmonary embolism following saphenous thrombosis from intravenous infusion, and I have seen fatal pyæmia, air embolism, pulmonary œdema and other complications. I suspect that the young student is inclined to forget that intravenous drip-infusion is only about fifteen years old, and that other methods of giving fluid are available—oral, subcutaneous, rectal intramuscular or intramedullary (sternum or lilac bone). The cavernous tissue of the penis has also been used, but I would fear thrombosis here, with its unpleasant sequelæ.

Care of the Colostomy.—The colostomy may need trimming after fourteen days. This is done to make a good opening to mitigate against the likelihood of stricture at the opening. Stricture may also occur at the skin level, unless a circle of skin is removed at the time of the operation.

The patient is instructed in the technique of colostomy washout. If a washout is performed each morning the colon is emptied, and the rest of the day may be spent in relative comfort. Nitch has devised a horn which fits onto the cup of the colostomy belt, through which the efflux can be led into a receiver, whilst the catheter admitting fluid can be introduced into a second opening in the cup. Gabriel has seen cases of perforation during washout, but I think that the risk is slight if the patient introduces the catheter himself. The cup for use during the day is more like a flat disc. The old-fashioned hollow cup is thought to induce prolapse and hernia at the colostomy opening.

The perineal wound usually closes slowly and steadily, although the patient need not be kept in bed until it is healed, for this takes about six to eight weeks. He may well get up in two to three weeks.

Bladder function begins to return in five to ten days, although it may be necessary to guard against retention with overflow for longer than this, by the occasional passage of a catheter.

Complications.—Ileus and retention with overflow have been mentioned, and the appropriate prophylactic treatment. Stricture at the colostomy opening and at the skin level should be prevented by taking care that both openings are made adequately large, for inevitable contraction occurs. Prolapse of the colostomy sometimes occurs and should be prevented by taking care that no excess colon is left above the opening. Hernia is also likely to occur, for the colostomy itself naturally weakens the abdominal wall. Both these complications are seen in a patient at present in Queen Ward. A loop of small intestine may become insinuated between the colon and the lateral abdominal wall, producing intestinal obstruction. A loop has been known to slip through the sutures of the pelvic floor. Both these tragedies should be prevented by proper suturing at the operation.

Osteomyelitis of the tip of the sacrum (or coccyx) can produce slight annoyance.

Bleeding from the distal loop of the colostomy, in inoperable cases, may be difficult to deal with. Bleeding when the tumour has been removed suggests a second tumour. This is particularly likely to occur in cases with multiple polyposis. So great is the danger of cancer in this condition, that total colectomy must seriously be considered.

29.53.69.

Orpington, 1939-1945—Part II

By MAURICE CAMPBELL, O.B.E., F.R.C.P.,
Medical Superintendent, Orpington County Hospital

THIS is not the place to record even the local aspects of the Battle of Britain, but living in Kent,, it is hard to write of other things without referring to that colourful background—the trail of white smoke in a blue sky; the pursued and pursuing planes glinting in the sun; the staccato crack of machine-gun fire; and, most beautiful of all, the shining white parachutes as some luckless pilot sought safety when his plane was crippled. At first, when the attacks were mainly against shipping and the ports, there were only isolated incidents, but as the second stage was reached (about August 16th) and the centre of the attack moved from the coastal aerodromes, such as Manston, to the more inland ones such as Biggin Hill, aerial activity became a more constant feature of our daily life. In the third stage (September 7th and after) as the attack passed to London, at first by day and later by night, Orpington began to feel a greater concern for London, though it still received its share of attention in passing.

In July, 1940, we began admitting our first pilots who had been shot down in the Battle of Britain. One of the earliest was Pilot-Officer Hugo, who was wounded in the leg and forced down almost over Sidcup. Most of them recovered well and quickly, though there was often a struggle with the R.A.F. authorities to avoid transferring them. Flight-Lieut. Kingcombe was admitted with a similar wound. I remember him well from my first visit to Biggin Hill: he was reading a book in the pilots dispersal hut, when a call came for a sortie over the coast and, on his return some forty minutes later, at once settled into his deck-chair and resumed the book as though he had merely been away for a quiet walk. Both these officers (and several other ex-patients) have had distinguished careers in the R.A.F. since, and these two are both Group-Captains with the D.S.O. and D.F.C. Many others have, unfortunately, lost their lives.

On August 31st, as I was walking up the hill to the hospital watching one of the usual dog-fights, we saw for the first time a parachute descent from a plane that burst into flames. On a sunny morning, with the light reflected so brightly from the parachute, it made a beautiful sight and we hoped it was a German plane. But about an hour later Squadron-Leader Gleave was brought into hospital very severely burnt. He was with us for two months before he was fit to be moved to East Grinstead and, after his recovery, included some of his impressions of the hospital in "I Had a Row with a German" (MacMillan, 1941). "High Endeavour" by Edward Seago tells the story of another ex-patient.

In August the attack on the aerodromes of South-East England developed and, from the point of view of Orpington, this meant Biggin Hill. On Sunday, August 19th, just after Scott had finished his game of golf on the Downe links, they were severely bombed and one man playing was killed. Later that day the two first military air-raid casualties were admitted—one with a wound of the shoulder, and one with hysterical aphonia; the first two civilian casualties were admitted on September 3rd, exactly a year after the war had started. This episode alone illustrates how difficult planning in war-time usually is, for the organisation of the E.M.S. was mainly built up to deal with casualties, and there was great reluctance to give us what was needed for the medical work that formed a large part of our early evacuated cases. Even September 7th did not bring us many air-raid casualties, but on the 18th we admitted twelve local casualties—about the usual number for an incident in this residential area—and on the 19th the same number from Bromley. But this is going ahead too fast.

On August 30th Biggin Hill suffered its most severe direct attack in the early evening (800 aircraft were used on that day and the next in a determined attack on the aerodromes of this corner of England, "The Battle of Britain," page 14). We got a message that several casualties were being sent to us, but most of them were admitted to Farnborough. I sent two medical officers up to Biggin Hill to give what help they could, and this was really the start of our long and friendly association with the aerodrome and its officers. It was for their work that night, I think, that the first three W.A.A.F. personnel received decorations; two of them were patients in the hospital later.

At 2.15 p.m. on September 1st the hospital received its first bombs. One fell on a shed between Boundary House (the headquarters of Professor Johnston and Sector X) and the Nurses' Home. A second fell on the lawn in front of the Home and was thought to be unexploded. A third hit the boiler-house—our only brick building in

the hospital. The boiler and end wall were destroyed, but luckily the structiure was a double one, and the other boiler could be got into working order and the service resumed. This was a lucky escape because it was the one spot in the hospital where a single hit might have paralysed everything, and we were still luckier in that there were no casualties. The ward nearest to this suffered considerably and a large projecting bay was blown right away from the rest of the ward. Some large parts of the boiler were found round about, so it was thought to be a blast effect from the boiler-house, but later it was found that a fourth bomb had come down between that hut and its projecting wall and had luckily gone very deep before it exploded and left a huge underground crater. How the patients in this ward—all elderly women—escaped injury was marvellous, but the furniture was thrown about and, of course, all the windows broken.

It was a Sunday afternoon and I was in London, but when I got back I found Dr. Scott and Mr. Dowers had dealt with everything excellently. The nurses had been cleared from the Home to two empty wards, and a bomb-disposal squad from the R.E. were at work on the crater in the lawn; the next day they found it had, after all, exploded, and there was a large cave 20–25 feet down. After this day providence seems to have watched over the hospital, for though a considerable number of bombs, including some of much larger size, have fallen on every side, often unpleasantly close, no others have fallen in the hospital grounds.

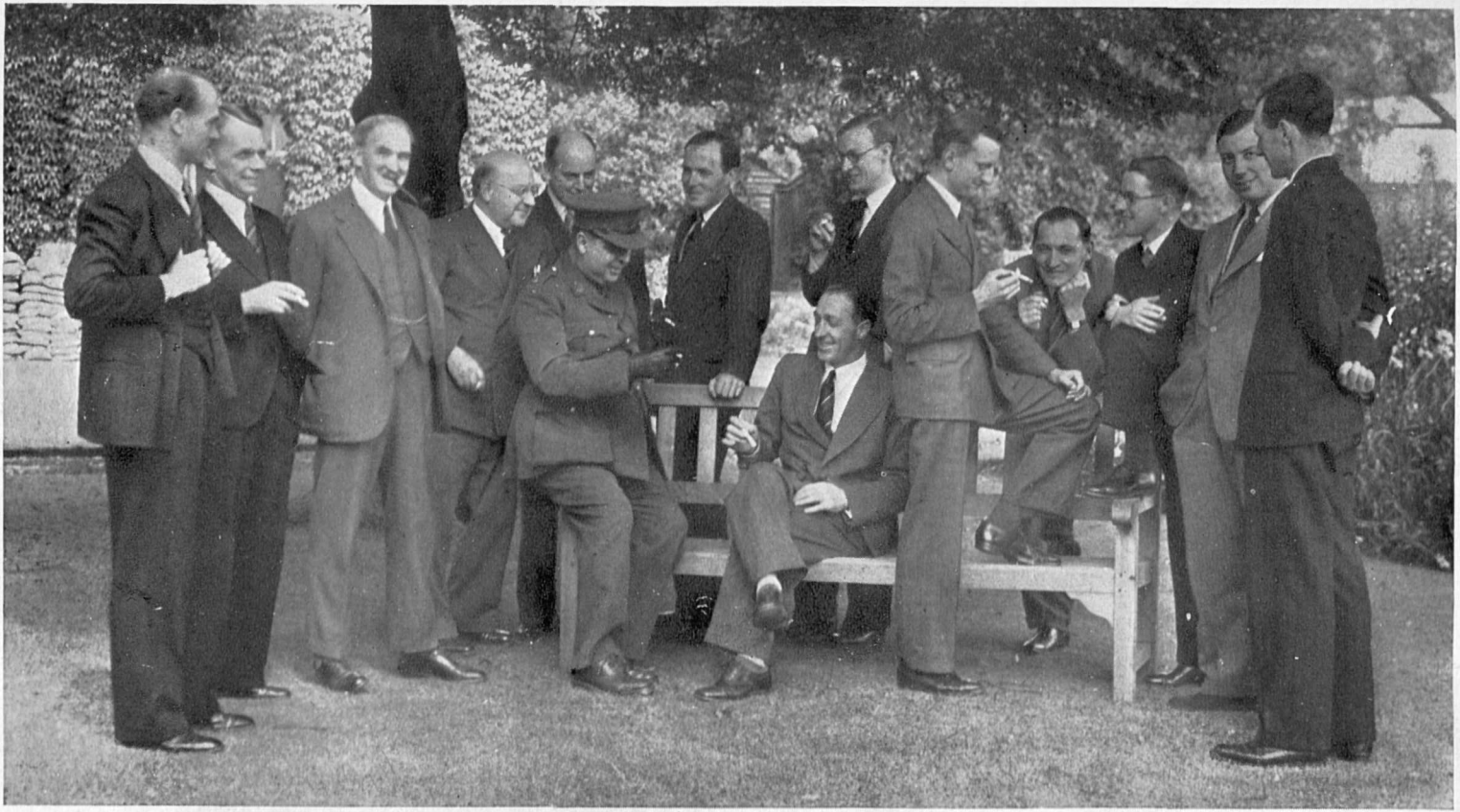
Saturday, September 7th, will be forgotten by few Londoners. We had often seen German planes in small numbers, but never before or since did we see such large formations in perfect order flying up the estuary towards London. As I went towards the station a heavy cloud appeared in the sky, and during the journey to London the fires got closer and closer, until it seemed that the train would probably be unable to proceed. After two hours I remember the train stopping on Charing Cross bridge as another alert had started, and a sculptured lion standing out clearly against the red glow of the fires—a fine symbol for the London of the next ninety nights.

As soon as the "blitz" started the great shortage of men in the hospital at night raised serious problems. Finally it was arranged for six members of the Friends' Ambulance Unit to come to the hospital Although their primary duty was to unload ambulances at night, and they slept in turn in the reception-room for this purpose, they performed many and various duties in the hospital during the day in training for their work overseas. Though the individuals changed they remained with us as a party till near the end of the war, and performed a most useful service. Even so, we were desperately short of men at night, and fire and incendiary bombs were a great anxiety. Luckily we were never tested in this way, even in the period when incendiaries could be seen falling all round.

Clarke (later I.M.S.), Hammond (R.A.M.C.), Budd (R.N.), Fung (R.A.M.C.), and Brian Johnson (R.A.F.) were all with us as house-officers at this time (November, 1940) and the latter's second impression of Orpington follows:—

"The change that had taken place was as amazing as it was fundamental. The theatre and the wards had been equipped—meagrely, perhaps—and there was a whole new block of modern, if utility, wards. The wards had patients; there was a surgeon's room with a dart-board; and Mr. Laurenson had arrived. Somehow I shall always feel that his particular personality and Orpington are peculiarly linked. The orthopædic octopus had begun to spread its tentacles; Mr. Batchelor could be seen sneaking into the New Theatre to put on a few plasters—on an old table, which was evidently all Mr. Laurenson would allow him. The "blitz" was on, and all experienced a most peculiar bond born of facing danger as a community—and this meant sisters and nurses, too. There was a dance in the Doctors' Mess the second night after I arrived, and many more; the spirit of good comradeship in work and in play was at its height. I shall never forget the nine months I spent, first as House-Surgeon and then as House-Physician; they were months packed full of work and friends and fun, and tragedies too, but they were months of full measure—pressed down and brimming over."

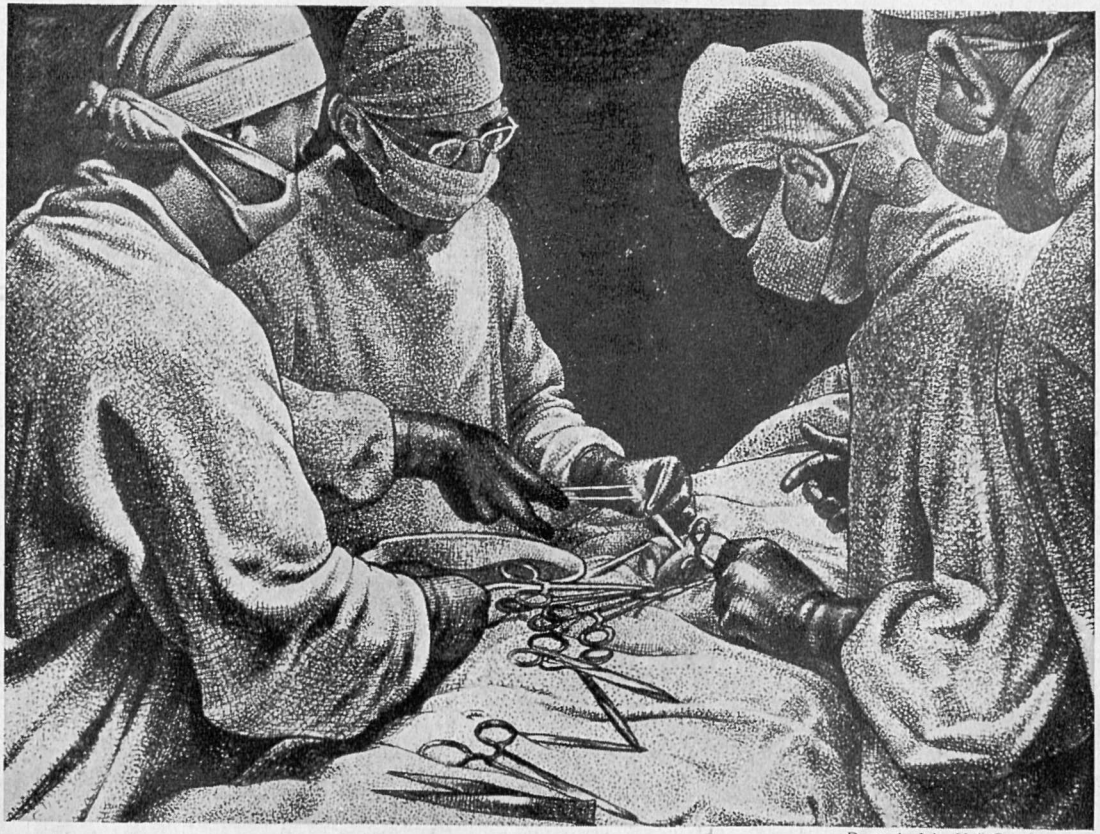
Impressions of September to December, 1940, during the height of the London "blitz" are probably common to all Londoners. On many nights we admitted small numbers from local incidents, but were more occupied with evacuated cases, from Guy's and elsewhere—once a hundred in a day, when Farnborough had been hit and needed to transfer some of its patients. I remember one night during a heavy raid when two Green Line ambulances arrived with air-raid casualties from Guy's, who had probably been told that they were being moved to a safe place in the country,



(*Reproduced by kind permission of* H. R. *Marchant*, F.I.B.P.

Medical Staff taken in the garden of Boundary House, June, 1940.

Reading from left to right.—Messrs. Batchelor, Laurenson, Campbell, Scott, Doherty, Major Philpott, Mathewson, Van Steytler (sitting), Eve, Hawkins, R. A. Johnson, Roberts, Knight, Bucknall.



Drawn by John Hall Grundy

Mr. McNair operating in the Old Theatre, Orpington Hospital.

Drawn by John Hall Grundy

Dunkirk Wounded in Addison Ward, Orpington Hospital.
Exhibited at the New English Art Club in their "Around England Exhibition."

Drawn by John Hall Grundy

Mr. Batchelor doing plasters in the New Theatre, Orpington Hospital

when there was a specially heavy raid and copious shrapnel falling and we were glad to get the patients safely into the ward before any of them were wounded again.

But even if it was not as unpleasant as London, it was unpleasant enough here; night after night we heard the planes droning over, often with very heavy local gunfire. Scott was a tower of strength and, with the other medical officers, went round the hospital again and again till a late hour of the night. The original air-raid shelters easily filled with water. When things became worse we insisted on forcing our way into an old tunnel under the railway, which made a wonderful natural shelter. Gradually our surface shelters materialised, they were much more comfortable and some nights were crowded with patients, but many could not be moved, and were protected as well as they could be with extra mattresses, or under beds, from broken glass if from nothing else. Much the same plan was adopted with the nurses off duty. This certainly gave confidence and people slept and felt better.

The nurses on duty were wonderful throughout this time, and the sisters were often in the wards by night as well as in the day, and often slept there, but I think all liked to feel that the doctors were wandering round and visiting the wards from time to time. Most of the patients were very calm, even those who were already casualties. There were odd scenes in many places, but nowhere more than in the Old Theatre at night when no casualties had been admitted, with a mixed collection of people sleeping in crowds on the floor of the different little rooms, for the heavy sand-bagging of the Old Theatre seemed to be some protection, and it was the most convenient centre for making any needed arrangements. The office staff generally slept there, and when casualties were admitted it was most useful to have them.

One picture that would have had great beauty but for the anxieties and sad thoughts that it called up, recurred much too frequently. From the hillside on which the hospital is built one could see through the near belt of well-wooded country the red glow in the sky as fires spread locally or more widely, and imagine the many tragedies that were taking place. Mr. Dowers had a heavy responsibility for the male fire-watchers were few, and with wooden buildings covering such an extensive area the risks seemed great. He must have had very little undisturbed sleep during those three months. Mr. Dowers has given me the following notes about the fire-watching :—

"The story would be incomplete without reference to the quiet labours of that little band of volunteers who undertook the task of fire-watching. Here at this hospital was one of the greatest fire risks under the K.C.C. The grounds cover 39 acres with the hutments all spread on ground floor with an approximate roof area of five acres, this being composed mainly of wood, covered with bituminous felt or cement asbestos tiles, so that they were as vulnerable to falling shrapnel as to the heavier incendiary bombs. They housed some 650 aged and infirm patients as well as the E.M.S. patients, which brought the total to about 1200. The team, therefore, took every opportunity for collective practice. There were a goodly number of hydrants; these were plainly marked, and all equipment put in a position to be ready at the various points in the shortest time and a central spot chosen, from which the observation posts radiated, to provide for adequate communication with the main buildings. The quiet hours were utilised to place reserve water cans at points of vantage, sandbags, buckets, and later stirrup-pumps, rakes and shovels.

"Then there was the total darkness to become accustomed to, as the blackout was rigidly kept, and to move together in the dark with real sense of direction with ones' partner required considerable practice—locating hydrants, emergency doors, etc., and developing a knowledge of fire-drill under such conditions was no small task. To accomplish this they turned out at every air-raid, day and night, keeping a watchful eye on their section and a keen ear for the shrapnel which at times appeared to fall in showers to throw up little sparks of light where the metal struck some hard stone on the pathway. With no shelter from this hail of shrapnel from the barrage put up by the guns, the fire-watchers at the Main Post also unloaded the various ambulances which came after darkness. No demand was too great, even when it became a nightly and an all-night occurrence; the readiness with which they turned to any task allotted them just proved their unity of purpose and that there is still great consideration in man for his fellow-men.

"The bitter experience of being out of doors in the cold bleak winds and rain of November nights became almost unbearable, and having gained considerable team practice, a shed was built as a shelter and Main Post, with a roof of corrugated sheet and a layer of sandbags and with a steam radiator inside; here they held court, in readiness for any occurrence. Here each evening until daybreak they reported for

service, sustained only by their goodwill and a cup of that famous "Mazawattee" brewed by Tom, who, in spite of rationing, never failed with his midnight cup and the telling of many a good tale to the party. When the hospital suffered damage, it was by this little team of workers that the fire to the shed was brought under control without any outside assistance; and, later, when the railway track at the back of the hospital was damaged and flames shot high in the air from the burning of the wooden boards encasing the electric cables, they scaled the fences and barbed wire to reach the railway and extinguished the fires.

"All this was prior to the compulsory Fire Watching Orders or the provision of assistance from the A.F.S. team with their trailer pump stationed at the hospital, and naturally when such schemes were made later it was from this little group came the natural leaders of the various teams, which, from February 1941 onwards, were to take up this duty. So, ere I close this note, may I express on their behalf, their appreciation of those to whom we passed over the casualties for further treatment especially to Dr. Scott and R. A. Johnson and Hammond (how he worked with us on a certain night will remain as a tribute to his understanding and energy), to the Sisters and Nurses who always seemed to be on duty, and ,lastly, to Mr. E. H. Heeley, our Chief—as ever, cool and calm—probably reading over his daily notes or solving some problem of the day, when it seemed that between the glare of fires, the hum and drone of machines and planes, and the noise of gunfire, of bursting shells and of exploding bombs, that hell itself was being let loose on earth; nothing perturbed him, and he was a noble leader to those quiet men who did this service and, when the horrors of war ceased, slipped back into the ways of peace."

But apart from work in the day, and raids at night, we did not allow other activities in the hospital to come to a standstill. Hockey had started early in the war on the field at the top of the hospital grounds. There were many inside and outside games and much keenness, but the season 1940–41 was the peak, when there was a league competition between six teams in the hospital, as well as many enjoyable outside games. Even the Medical Superintendent played regularly, often as centre forward, after an interval of twenty years. With some misgiving and with some criticism I encouraged dances to continue. I remember that one evening all the doctors were called away to wards and theatres as casualties were admitted, but numerically this made little difference as we had many visitors from Biggin Hill, and, on many occasions, we were grateful to them for sending over their excellent band. We also had many pleasant return visits there.

In November, 1940, Group-Captain Grice, the station commander, left Biggin Hill; few who attended his farewell party will forget the evening. We had got to know him well and felt he had done excellent work with his large numbers of young pilots during the Battle of Britain. Curwood had been in medical charge, but he ,too, left in 1941. Colbeck was in charge of the E.M.S. pathological laboratory at Downe, and was often in the hospital, and helped us greatly with many problems as we had no pathologist on the hospital staff. He was an even more constant visitor to Biggin Hill and had established a great reputation there for courage and helpfulness during the "blitz." The association with Biggin Hill was a great pleasure and several of the senior staff were made honorary members of the mess—a privilege that they valued highly. The part played by Biggin Hill, as the main fighter station of Group XI, with such a long list of victories to its credit, is now history. "Readiness at Dawn," by Blake (Victor Gollancz, 1941) was supposed to be written about Hornchurch, the main rival aerodrome on the other side of the Thames in Essex, but it might have been a perfect description of the life and activities of Biggin Hill, and many pilots had been at both aerodromes.

On April 16th, 1941, the military section held a dinner at the "White Hart" in Bromley, to celebrate their first year's work in the hospital. It was a cheery occasion and rather noisy, so that we were first aware of a raid being on when the room was shaken by a near-by bomb. Soon after there were showers of incendiaries, some in the inn yard. After a time Scott and I returned to the station through piles of broken glass and burning incendiaries, but the bombs continued to fall round the station. We felt that Bromley had been singled out for special attention, but realised later that most other parts of London thought the same. After a long wait, as there were fires at both ends of the station, we started to walk back and passed many burning houses and some large craters in the road. On reaching the hospital we found this busy with casualties that had been admitted; and Scott and the surgical staff spent the rest of the night in the theatre. We admitted 92 air-raid casualties that month and 46 in the first half of May, after which there was relative freedom until the raids of 1944.

The heavy raids of May 10th–11th were less noticeable at Orpington. I remember spending the following night at West Malling aerodrome, and regretting I had not been there the night before when they had been successful in shooting down several Huns. However, I had the pleasure of flying back over Orpington and seeing the hospital from the air. We have continued to have a good many patients from West Malling, and the M.Os. stationed there have frequently visited the hospital. I am indebted to Squadron-Leader Elliott, R.A.F., for the picture of Orpington from the air. (See later).

After these vivid memories of the first twenty months of the war, the next three years seem to have been an unbroken period of hard work with few special memories, though in 1941 there were still important steps in the growth of the hospital. In January, 1941, Orpington became an orthopædic centre. Stamm had been working here since June, 1940, and Batchelor since early in the war. Soon after the whole of Hunt Ward was gradually equipped as a room for physiotherapy, and Crisp was a great help in dealing with the apparatus involved and keeping it in working order. Here each morning is one of the most crowded and varied scenes in the hospital. Miss Stevens and Miss Wareham from Guy's and Miss Hamp and Miss Blundy in succession as our own head physiotherapist have been in charge of their respective groups, and have worked together well under Crisp's general guidance. He has also had to fit in the claims of occupational therapy and the army P.T. sergeants, and often the men's days have been fully occupied. I think this has helped to produce a contented happy atmosphere among the patients, but I cannot see P.T. being continued among civilians as hospital routine, as some of its enthusiasts expect.

The orthopædic cases have grown and grown in number, and have generally occupied more than half the hospital. I think that Lambrinudi and Stamm, who both worked here but had duties elsewhere, would wish me to say what a large share of the orthopædic work has been done by Batchelor; operations, plasters, ward rounds, out-patients', and board reports have kept him busy for a longer day than most people could stand, and much of the outside reputation of the hospital depends on the enormous amount of work he has managed to do himself, and has taught others to do competently. For a long time he lived in the hospital and was also able to help us at night.

In September, 1941, Lambrinudi joined us. As he had military out-patient clinics in different parts of Kent, the service in-patients increased within a few months from 250 to nearly 400. It has since varied between about 350 and 500, except after the flying-bomb evacuation. This led to a great increase in the staff of physiotherapists. In November the orthopædic section of the R.S.M. met at the hospital and Lambrinudi gave the presidential address. It was a great pleasure having Lambrinudi here, and his vital and provocative views led to many interesting discussions. Although to those who knew him there were signs that his long illness was progressing, he carried on with a most active life and was operating here a few days before his death in April, 1943. As the orthopædic work in the hospital increased more wards were given over to be run entirely by members of the Civil Nursing Reserve, and soon the number of them working in the hospital totalled 100. Sister Willis moved from Ward 7 and ran Mary as a most successful orthopædic ward. She was, I think, our C.N.R. sister with the longest period of work here.

This orthopædic work led to the opening of the occupational therapy department, and a carpentry instructor soon followed and Mr. Peddy has proved a great success and has been in charge throughout. Both these sides have been immensely popular, especially with the soldiers, and if it has been found that a relatively small proportion benefit in the strictest sense by being made to use the damaged limb or fingers, it has been equally valuable for a much larger number by providing an interesting and useful occupation that has helped to keep patients interested during long spells in hospital. As in other branches of life, fashions have followed each other, and different toys or model aeroplanes or rugs or various pieces of fancy work have succeeded each other as the most popular products. Perhaps the most characteristics memory is of soldiers leaving the hospital, no longer in "blues," walking along Tower Road carrying a rocking duck.

In February, 1941, Miss Ricketts came from Guy's to work as almoner, and soon after combined this work with being secretary to the Medical Superintendent. She held these combined positions till December, 1943, when she was officially appointed as Almoner, and was succeeded in her other duties by Mrs. Doherty, who remained till

some months after the war was over. Considering the office work to be got through during this busy period, and at times the lack of help, the hospital owes her a great debt. Always cheerful and enthusiastic about her work, she has been an ideal almoner, and very many patients and friends will be grateful for her help.

In May, 1941, after a difficult period, the position of Matron became vacant and Sister Marriott was chosen. This, of course, was a K.C.C. appointment and did much to help in welding together the different elements of the hospital. Two deputies were appointed—Sister Dornan, especially for duties connected with the Guy's School of Nursing; and Sister Peake (succeeded in 1943, when she became Matron at Dover, by Sister Coulstock), especially for the non-E.M.S. side of the hospital. The method has worked admirably, but few can realise as well as the Medical Superintendent what a burden of work and responsibility is thrown on the Matron of a large hospital with 1200 patients and 360 nurses. Many of the difficulties came first to her, and the variety of problems she has to solve is almost incredible. In July Mr. Burrows came as assistant to Mr. Dowers, and stayed with us till he attained a more senior appointment at Plymouth after the war; he loved an argument about the relative merits of the voluntary and municipal hospitals, but would have given good service to either.

On July 8th, 1941, the Bromley and District Guardians Committee met at Orpington for the first time, Farnborough, where they had met previously, having been taken over by Public Health under the 1929 Act. From this time on I attended their meetings regularly with the Matron and Mr. Dowers, and though the Group Officer, on behalf of the Ministry, was in charge of the medical stsaff and the movement of patients and gave general directions about their treatment, this committee was the governing body of the hospital under the P.A. Committee of the K.C.C., and this continued to be the case until the hospital was taken over by the Public Health Committee on April 1st, 1945. Mr. W. A. Waring, J.P., the chairman until his death, and Mr. Badder, the A.P.A.O. who acted as secretary, were always anxious to help, as was Colonel Heilbron, the chairman of the subsequent committee. They dealt mainly with the day-to-day administrations, appointments, wages, repairs, etc. Several problems still unsolved were already before the Committee—difficulties with the laundry, shortage of linen, and the absence of a "foul washer." About this time the Staff nursing the chronic sick went down in an alarming fashion; and in August, 1941, Guy's nurses were again working for periods of one nmoth at a time in these wards as were almost half of the C.N.R. The staff situation has improved in these wards since, and Guy's and C.N.R. nurses now work entirely in the E.M.S. unit.

There had, of course, been no pathological facilities of any sort here, and at first specimens had to be sent to Farnborough. The difficulties in getting such a department established on the smallest scale, were even greater than usual. But gradually during 1941 it got going. By October the equipment provided by the Ministry had arrived; and Scott, who had already been doing some of the work, was transferred here whole-time from Farnborough as pathological technician. In a converted side-room he has carried out all the routine work to the satisfaction of all. But in a hospital of this size there are many drawbacks in not having a qualified pathologist, and it has thrown extra work on the medical staff, especially with blood transfusions. In spite of this I think the standard maintained here has been most creditable to the medical officers who have been mainly in charge, though from time to time there have been difficulties that would have been much easier to solve with a pathologist on the spot. Coming on to July, 1944, when penicillin began to be available, we had much help from Dr. Hutchinson, who had followed Colbeck at Downe.

On January 1st, 1942, Miss Barnes was appointed Kitchen Superintendent, having previously managed the kitchen and catering at U.C.H. The kitchen was old-fashioned and crowded, with little modern equipment, and there were many complaints about the food. An elderly ex-naval cook was in charge and, though he was a charming old man, he was unwilling to change or improve, and retired. Miss Barnes worked wonders, and gradually built up a good kitchen staff, and with some atructural improvements and extra equipment (far short of what everyone would wish to produce a modern kitchen) changed the dietary and cooking so that nearly all the patients were pleased—a remarkable achievement with the increasing difficulties of supplies and rationing. The size of the problem may be easily visualised by the following facts: 7 cwt. of potatoes have to be prepared for one dinner; 160 lb. of flour are needed to give puddings to each ward; and 84 lb. of jam provide only a helping of jam-tart for each patient.

Early in January privilege leave became available for soldiers in hospital. In 1940 we had been able to recommend sick leave, but this power had been taken away, probably because it had been abused in some hospitals. Possibly our strong representations to visitors from the War Office of the advantages of soldiers in hospital being able to have leave, may have helped in bringing about this change.

In June, 1942, we were saddened by the death of Group-Captain Barwell, D.F.C., shot down over the Channel. He had been O.C. Biggin Hill for a year and had become a firm friend of the hospital. He visited all the R.A.F. patients nearly every Sunday, and was with us on many social occasions, and had himself been a patient here with a fractured spine and had managed to resume flying (non-operational) while still in plaster. We felt that the attitude of a succession of station commanders at Biggin Hill was more than ample return for anything we were able to do for the R.A.F. patients.

(*To be continued.*)

Pupils' Physical Society

DURING this late war, the Physical Society was unfortunately dormant at Guy's, though spasmodic meetings were held in the Sector Hospitals. On February 4th, however, a general meeting was held in the Physiology Theatre, when Dr. J. M. H. Campbell gave an address on the history of the Society. He traced its progress from 1830, when it sprang from the earlier Physical Society (from which students were excluded), up till the outbreak of the Second World War, naming many famous men who were members or who gave addresses, and quoting extracts, grave and gay, from speeches and case-reports recorded in the Minutes. He was able to produce for inspection some of the very early Minute Books, with yellowed pages but beautiful, and still easily legible, handwriting. Dr. Campbell's interesting talk was received with acclamation by a large audience.

After the address, the members of the Society unanimously voted for the holding of further meetings during the spring. A Committee of Presidents was elected from among students and housemen, and this committee later proceeded to nominate an Honorary President (Sir William Hale-White has kindly consented to accept this office), Honorary Vice-Presidents, and Honorary Secretaries. It also decided to approach St. Thomas's Hospital Medical Society with a view to reviving the joint clinical meetings which used to be held before the war.

Five meetings will be held during the spring, the first (a clinical case demonstration and discussion) on February 21st. The details of each meeting will be prominently advertised in the Hospital, and it is hoped that good attendances will result. All members of the Club's Union are, by virtue of such membership, also members of the Pupils' Physical Society, and are entitled to come to the meetings. The Committee wishes to emphasise that the Pupils' Physical Society is essentially a students' society, though qualified men are of course equally welcome. But no student in his clinical period should be deterred from attending the meetings by the fear that they are too advanced for him, or that they are learned highbrow debates. They never have been in the past.

Programmes of the present session will not, in view of its brevity, be issued, and the Society's Prizes will not be awarded this year. But a full session is promised for 1946-47.

The last pre-war Minute Book of the Society is unfortunately missing. Anyone who has knowledge of its whereabouts is asked to communicate with one of the Honorary Secretaries (Dr. J. R. Forbes and Mr. J. E. Spalding).

J.R.F.

Correspondence

FIRM DINNERS.

To the Editor of the GAZETTE.

SIR,—Guy's has long been noted for two features: (i) the practical character of its clinical training and (ii) the close relationships between members of the staff, junior staff, house officers and students. These two characteristics are to some extent inter-dependent and anything which will help to facilitate closer contact, both

professional and social, between the various elements which constitute Guy's is obviously desirable.

Until the war of 1914-18 firm dinners were a recognised institution, at any rate on the surgical side, and were given by the member of the staff, who entertained his dressers and ward clerks to dinner and often to a theatre as well. After the war the increased size of firms, curtailment of domestic staff and ever-increasing taxation made firm dinners on the Edwardian model impossible, though some members of the staff continued to give less formal parties. Shortly before 1939 a few firms took the iniative and were hosts instead of guests.

Personal experience of firm dinners, both as host and guest, has convinced me that these social functions are of great value in initiating contacts and friendships which may last long after student days are over. As regards your suggestion to substitute coffee for alcohol, most will feel that they should be free to partake of what they prefer.

Finally, I would point out that whatever debt students may owe to their teachers, the latter benefit to an incomparable extent by the stimulating effect of constant association with students.

I am, etc.,
J. J. CONYBEARE.

Guy's Hospital, S.E.1.

(*We agree with Dr. Conybeare that people shold be free to partake of the beverage they prefer. We did not, in fact, suggest the contrary—but merely that the emphasis might be on the one rather than the other.—Ed.*)

To the Editor of the GAZETTE.

SIR,—May I, through the agency of your long-suffering columns, take the opportunity of thanking my firm for the magnificent firm dinner which I attended last week. My acceptance, far from being perfunctory, was infused with a spirit of the most lively anticipation. I can only hope that the firm enjoyed themselves as much as I did. No doubt we would have spent our time more profitably discussing Camões or Tasso over a cup of coffee in the Medical School Committee Room. As it was our party had no more serious purpose than, as the poet has it, "laughter and the love of friends."

I am, etc.,
H. J. B. ATKINS.

Guy's Hospital, S.E.1.

To the Editor of the GAZETTE.

SIR,—We, as "younger members of a firm," were surprised that such a large amount of precious newsprint was allocated, in your last issue, to the deprecation of the now well-established tradition of firm dinners. Perhaps it is a reflection of the present day trend for interference with the personal liberties of the individual.

We doubt whether the opinions expressed either in "Passim" or in this letter on this controversial subject will affect the inclinations of those concerned. Whether there is to be a firm dinner or not, whether it is to be held at a tavern, a high-class restaurant, in the streets of the Borough, or at the residence of the member of the staff concerned, is a matter to be decided by those participating alone.

We would point out that a firm dinner is a function arranged solely at the instigation and expense of the students of a firm. Surely the manner in which the evening is spent is one for individual taste, whether it be for coffee or beer; provided that no inconvenience is caused to non-participants, we feel that the discontinuance of firm dinners in their present form, being as they are most enjoyable functions, is both unnecessary and undesired.

We are, etc.,

E. BESWICK.
K. M. CITRON.
M. W. J. GRUMMITT.
D. F. N. HARRISON.
A. H. MENDOZA.
A. E. McLAUCHLAN.
N. H. PORTER.
J. D. WILLIAMS.

Guy's Hospital, S.E.1.

THE HISTORY OF GUY'S DURING THE WAR.

To the Editor of the GAZETTE.

SIR.—I enjoyed very much reading the first instalment of Dr. Campbell's article on Orpington, and I feel sure that this account will not only be of special interest to all who worked there, but will also be sought after by all those Guy's men and women who are anxious to learn of the services rendered by Guy's to the war effort.

Some time before the war had ended the *Gazette* Committee decided to sponsor the publication of a History of Guy's during the war. It was thought at the time that this might be entrusted to a single author who should be empowered to collect what material and information ho needed and to invite collaboration when he thought it might be necessary. It occurs to me that this History is now in the process of writing itself in the current numbers of the *Gazette*, and that in due course the History will require not an author but an Editor, or perhaps a small editorial committee.

Accounts have so far been supplied of events at Guy's, at Pembury, and at Orpington, and I hope we shall see published in the near future articles concerning Farnborough, the Wildernesse and other hospitals in the Guy's sector, with perhaps something on the lines of the Book of Job from Boundary House. There might, with advantage, be a report of the activities of the war-time Medical School from the scholarly pen of Mr. Evans. All these should make good reading.

But perhaps the prospect of being condemned to so long a future period of war-time reminiscences in your pages may fill even your stoutest and most loyal readers with apprehension, and you, Sir, may decide in your editorial wisdom to try to extract these articles as contributions to a separate volume.

I do feel, however, that there is one article, or series of articles, which should be written, and published by you, soon, and that is an account of the contributions of Guy's men and women to the Services. In this respect, Guy's must have an unrivalled record. Apart from the fact that the majority of Guy's men have served in the Armed Forces during the war, and many with distinction, 16 Members of the Honorary Staff were in the Army or the Air Force, and of these one reached the rank of Major-General, two became Air Vice-Marshals, and two Brigadiers, and one an Air Commodore. Their Commands ranged from India to Abyssinia, East Africa, North Africa, Italy, and the Home Country.

What a grand and glorious tale is theirs to unfold.

I am, etc.,

P. F. M. BISHOP.

Guy's Hospital, S.E.1.

Hospital Information, etc.

Pass List

THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.
December, 1945.
(For Internal and External Students.)

C. D. Baker — J. C. Schofield
G. B. Elphicke

SECOND EXAMINATION IN DENTAL SURGERY.
PART I.
December, 1945.

C. N. Furnivall — J. D. Morgan
J. B. Harris — L. G. Richards
R. L. Leader

The following Students are credited with Anatomy and Physiology :—

S. P. Gill — C. B. H. Watson
S. R. W. Powell — J. G. Whitelegg

UNIVERSITY OF CAMBRIDGE.
FINAL M.B. EXAMINATION.
Michaelmas Term, 1945.

PART I.—Surgery, Midwifery and Gynæcology.

E. M. M. Besterman — J. F. F. Rooney
J. A. Bulleid — R. E. Sidebotham
L. Haas — H. W. Trusted
K. E. Jefferson — W. Van't Hoff

PART II.—Principles and Practice of Physic, Pathology and Pharmacology.

J. C. Bayliss — E. B. Gethen-Smith
J. P. M. Bensted — M. W. P. Ward
J. E. Blundell

CONJOINT BOARD.
FINAL EXAMINATION.
January, 1946.

Midwifery.

S. Balfour-Lynn — R. V. H. Goulder
J. F. Delafresnaye — *F. L. Jackson
B. D. Grant — M. D. Warren

Medicine.

*P. K. A. Andrews — *H. A. R. Loxdale
*W. W. Cree — *T. C. L. Parry
*M. M. El Shinnawi — *R. E. Sidebotham
*E. B. Gethen-Smith — *H. W. Topham
*F. L. Jackson — *G. R. Wotton

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R. W. Day — J. L. Jenman
J. B. Eades — J. Niwes
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*E. B. Gethen-Smith

Surgery.

S. Balfour-Lynn — J. F. Delafresnaye
J. F. Cleobury — *W. M. C. Hallinan
M. B. Conran — *F. L. Jackson

* Have completed the examination.

EDS. {J.M.H. R.H.N.L.

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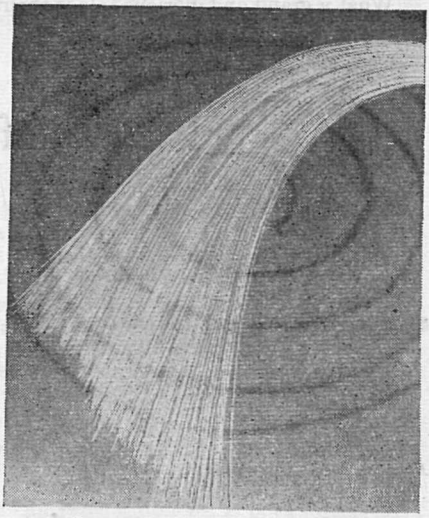

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GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

THE medical attention—in its widest sense—available for a student of this Hospital who is acutely ill is undoubtedly good. A large number could testify to the unstinted and skilful treatment they have received.

In a community of young men, however, a really serious illness, even any illness at all, is an unusual event, but when the community is made up of medical students there are certain factors which readily predispose to minor ailments; and it is these, often surreptitiously debilitating, that require appropriate and immediate attention. Any student, in the slightest degree concerned about his health, should know where to seek advice and where to obtain treatment. The great majority of students, having great faith in their own immunity to disease and living away from their homes and, consequently, out of touch with the family doctor, frequently have but a nebulous idea of what to do if they become ill.

Some interesting observations have recently been made by the Social and Preventive Medicine Committee of the Royal College of Physicians in its concise and excellent Report on Student Health Services. Perhaps the most outstanding and surprising feature of this Report is the stress laid upon the prevalence of psychological disorders among students. The very term " psychological " may arouse in the lay mind a feeling of suspicion. There is a dangerous tendency to regard it as applying solely to manifestations of gross mental disease, whereas, in fact, it embraces a whole host of curable and not uncommon forms of mental instability. The Committee suggests that a psychological test should take its place with a physical examination of the student on entry and, further, that there should be periodic but regular re-examinations to discover whether any physical, or mental, defects are developing. We agree that the revelation of mental disturbances, either at the primary examination or subsequently, should not be an indication for the rejection or dismissal of a student, but for the need of prompt and confidential advice from an expert. The appointment of a medical officer for the general supervision of student health—a consideration put forward by the Committee—would appear to be a matter of relative ease in a large teaching hospital.

The Committee mentions specifically the problems of diet and lodgings. In the present dearth of food and accommodation there is practically no hope of a satisfactory solution to either of these two important issues. It is abundantly clear that a number of students are eating the wrong kind of food and living in conditions which are not conducive to robust health. The financial aspect has, of course, a definite bearing upon the food a student eats and where he eats it—both during the day and when he goes " home " in the evening. Yet another matter, apart from several others we can think of, is the difficult position of the student who is ill in his lodgings. There is, surely, a degree of inadequacy interwoven with these problems of diet and lodgings which calls for a thorough investigation.

We would point out that our remarks are, in the main, directed towards the question of student health in general, although they must inevitably apply to conditions pertaining at Guy's in particular. We hesitate to offer any suggestions for a " student health centre " within the Hospital. The ultimate form of the National Health Service is still fluid and doubt exists over the future of the voluntary hospitals. These two factors together preclude the presentation of anything constructive at present. Nevertheless, we do envisage a simple, but efficient, student health service before long because so much depends upon the health of the student—his personal happiness, his ability to work and his success in life when his hospital days are over.

We referrred, in passing, to the National Health Service. It is probable that the Government White Paper on this subject will be published within the next few months. The B.M.S.A. is anxious to obtain an accurate report of student opinion on the Minister of Health's proposals so that its Executive may be furnished with the necessary knowledge of the views of as many students as possible should it be called upon to meet the Minister. It is proposed to distribute questionnaires to the medical schools four weeks after the publication of the White Paper and these should be back in the hands of the Executive, completed, two weeks later. It is the obvious duty of every student actively to express his opinion on this National Health Service, since he is likely to be intimately acquainted with the finished product once he is qualified; the facilities to be afforded by the B.M.S.A. will provide an excellent opportunity which it would be foolish to ignore.

"Some Aspects of the Future"

Presidential Address, delivered before the Guy's Hospital Dental Society on October 9th, 1945, by F. S. WARNER, L.R.C.P., M.R.C.S., L.D.S.

(*Abridged.*)

GENTLEMEN,—The War has brought about many changes in perspective, and many new ideas have become crystallised as part of the evolutionary process which the dental profession is undergoing. It is fascinating to look ahead and speculate upon some of the modifications in training and in practice which may be introduced as a result of the forthcoming report of the Interdepartmental Committee on Dentistry.

Serious attention must obviously be given to the ways and means of providing a more satisfactory dental service for the mass of the population. Without doubt this will necessitate a considerable increase in the number of graduates and licentiates on the register—a condition which can be brought about by making prospects after qualification more attractive and also by making professional training available to an increasing number of men and women. In fact, in the future the number of entrants to the dental profession is dependent upon finance. Individuals must be subsidised during training, and the dental schools must receive considerably increased grants from the State. It is quite impossible for any school to keep going—let alone progress—unless these are forthcoming. The training of dental students at the present time is fundamentally sound, and it would be a tragedy if any attempts were to be made to reduce the length of professional training. There will doubtless be some modifications in curricula. The future depends upon prevention—in other words, upon prophylaxis and not prosthetics. Then one may see a reduction in the length of time spent upon mechanics and prosthetics to the advantage of that spent upon chair-side clinical work. We may even lose comparative dental anatomy from our syllabus without shedding a tear. But, in the main, no drastic changes are called for, as the existing undergraduate training is basically sound. In comparison, what is the present position of post-graduate training? In this country it is almost non-existent. In no profession is it more vital than in our own. Existing schools, with perhaps new ones which will soon be built, would seem the proper places for the conduct of post-graduate instruction, for the increases in income which are essential to these bodies will make it possible to augment their number of half-time teachers to carry out this much-needed instruction. I trust you will all avail yourselves at regular intervals of these facilities when they are more freely available.

When, on a previous occasion, I had the honour of presenting a presidential address to the society, the subject was "The Need for Research." A plea was made for the encouragement of the more enquiring mind—its guidance along the right path—culminating in the creation of a research worker with a good knowledge of the basic sciences. It will surely be one of the recommendations of the Teviot Committee that more attention must be given to research. Let us hope that the ingenuity of the members of this Committee will give us guidance as to how research workers are to be trained, for this is, as in medicine, a perplexing problem. You will have read in the Press recently that the Nuffield Foundation is willing to finance the training of reasearch workers in dentistry in the future. Such a scheme is deserving of your deep gratitude.

Many are anxious about the future of private practice. Surely it is not possible to introduce a complete State medical or dental service. It would seem right that

such a service should be available to those members of the public who desire it, but it would appear likely that a not inconsiderable proportion of the population will wish to patronise the private practitioner of their choice, whose fees they are willing to pay. We are all conservative and reluctant to make changes in our mode of life, and I visualise this will apply to the dental practice. State-controlled clinics would logically be substituted for the present panel system of treatment. They could prove attractive to those who staff them as well as to those whom they treat. Dental treatment in its best form—*i.e.*, in the form of careful prophylaxis and conservation—is possible in any State scheme, provided that the latter is properly conceived and sensibly administered. As yet we are in ignorance as to the condidions which will prevail. I believe that the standard of treatment given to patients, from whatever stratum of society they come, and likewise the standard demanded by them, will continue to improve. Provided that you all fulfil your obligations to your patients—whether you are in private practice or members of a State service, you will enjoy the esteem which is your due. You will work hard without amassing a fortune. You will be making your important contribution towards the positive health of the nation. The whole future of dentistry is in your hands, and I am sure none of you will fail to do your utmost to maintain and to improve the good name which your profession enjoys.

29.43

Orpington, 1939-1945—Part III

By MAURICE CAMPBELL, O.B.E., F.R.C.P.,
Medical Superintendent, Orpington County Hospital

LOOKING back, 1942 and 1943 seem to have been otherwise uneventful, and the general course of events can best be described by using my report of 1943 to the Group Officer; it shows that there was no diminution in the work. I have made a few additions to save repetition.

The year 1943 has again been a busy one with an even higher proportion of occupied beds than in 1942. There is often difficulty in finding a bed in the right ward, as it is important to avoid scattering the cases of one department too widely. There has been a steady flow of wounded soldiers from overseas and, towards the end of the year, of repatriated prisioners-of-war. The year was marked by two outbreaks of Sonne dysentery, one of which also affected the nursing staff. Shortly after this there was a severe epidemic of influenza among the nursing staff; both of these led to temporary reductions in the patients admitted. On the chronic side the shortage of nurses has led to the closing of one ward. There has also beeen increasing difficulty in obtaining domestic staff.

1. E.M.S. admissions during the year have been 5,039, a considerable increase on 1942, all the more striking when the periods of reduced admissions were taken into account. They were made up as follows:—

ADMISSIONS TO ORPINGTON E.M.S. HOSPITAL, 1939–1945.

	Service.	*Civilian A.R.C.*	*Civilian Sick.*	*Total.*
1939 (3/12)	48	0	214	262
1940	1,528	320	1,275	3,123
1941	2,267	351	1,798	4,416
1942	2,506	85	1,877	4,468
1943	2,896	85	2,058	5,039
1944	2,482	322	1,686	4,490
1945 (9/12)	1,732	172	1,342	3,246
Total	13,459	1,335	10,250	25,044

Out-patients, mainly services cases, have remained at about the same number of just over 3,200, and as nearly all these are cases sent for consultation and requiring a reply, it adds considerably to the work of the senior staff.

II. The average number of patients has been 1,253 (against 1,192 last year). The E.M.S. patients have averaged 631 against 582 last year and chronic patients have averaged 622 against 610. The E.M.S. patients have been made up as follows:—Male civilian, 110; female civilian, 100; Service cases, 421.

III. The average length of stay shows little change. The service cases still average 51 days, and the average civilian figure is 37 days against 42 last year. Every effort is made to keep this as low as possible, and considering the type of cases I do not think it can be much reduced. Where patients are away from home, without full out-patient facilities, there is much more tendency for them to stay until they are fully recovered. The increase for the soldiers is, I think, explained by the larger proportion of the more difficult orthopædic cases transferred here from many other centres in Kent; and it was already long because of the need to get the men reasonably fit before their discharge. Two physical training instructors have carried out most satisfactory work in this direction, and though many patients have been sent to convalescent depots, a large number have been sent direct to their units, and I have received no complaints of men being sent back before they are fit for their normal duties.

IV. The operation and anæsthetic return shows that the total number of anæsthetics was 3,054 (3,983 in 1942, 2,679 in 1941), most of these being general anæsthesia. The total number of operative procedures was 5,037. It is satisfactory to be able to report once more that there has been no anæsthetic fatality since the start of the work, with a total of over 13,000 cases.

V–VII. The work of most departments has again increased, as shown by the following figures :—

Physiotherapy department, 110,010 treatments for 2,944 patients.
X-ray department, 12,781 films for 6,936 patients.
Pathological department, 10,622 specimens.
(The more detailed figures have had to be omitted for lack of space.)

VIII. The total number of medical boards has been 675—438 for regrading, 113 for discharge from the Service, and 124 underA.C.I. 2612/42 for the retention of a soldier in hospital for further treatment after five months.

It will be noted that in nearly all directions the work of the hospital has increased further. There has been no increase in the medical or nursing staff to balance this, and I do not think it would be possible for the present staff to do more than they are doing. Their work throughout the year has been most satisfactory. The amount of work with the present number of nurses has only been possible by having three convalescent wards completely looked after by the soldiers and with the care of one sister, and this has continued to work well.

MAURICE CAMPBELL,
January 28th, 1944. *Medical Superintendent.*

We were rather pleased with this arrangement for convalescent wards and felt that it did a little to help with the serious shortage of nurses. I hardly expected it to succeed, but it worked well and led to no difficulties. The soldiers were not keen on cleaning the ward though they did not mind dealing with their own food and beds, but as they were allowed to be out rather later, and to have the wireless on later, etc., they were satisfied. Sister Townsend was an admirable sister of these wards, understanding the men's point of view and controlling them readily.

The reference to medical boards recalls the amount of work that has been put into these by house-officers, by specialists, and by Scott and myself, and I am told that they have reached a very high standard of accuracy, so that real justice was done both to the claims of the soldiers and of the Army. After April, 1940, they were held regularly each week. The numbers increased steadily from 280 in 1941, to 880 in 1944, and over 2,500 had been held when the war came to an end. At first I shared duty on these with Scott, but for several years he had been the civilian member of nearly all the boards held. Major-General Blackham, C.B., C.M.G., has been chairman throughout the greater part of the time, and it has been a pleasure working with such an able and distinguished soldier. About one quarter of the boards held have resulted in the soldier being discharged from the service. Looked at in a different way, about 5 per cent of all the soldiers admitted have been discharged and 14 per cent regraded, often temporarily, which is not too high a proportion considering the severe wounds and injuries for which many patients have been admitted.

Brian Johnson's third impression of Orpington follows naturally after this report of increasing work. "After serving in the R.A.F. I returned in May, 1943. The experimental stage was over, the "blitz" was over, and most of the fun was over.

The hospital was smoothly efficient; it was much busier than I had known it in the past. The office staff had grown; there were more forms, but there was less laughter. I do not wish to imply that the hospital was sad—far from it—but it had lost the impression of self-creation, of embryonic growth. Improvements sighed for when I was last here had come about, or had been given up as hopeless; the constitution was fixed; all that remained was the work, for as far as receiving and attending acute cases of all description is concerned, we had advanced out of all knowledge. When we came we had huts and people; now we had a hospital, a unit and the professional efficiency and reputation, and these we jealously guard.

"I must consider myself privileged to have seen so much of the drama, for the birth of a hospital *ab initio* is an interesting and instructive metamorphosis to watch; of the men and women who worked to bring about this change I could write long—of the friendships that their communal efforts gave birth to, I could write longer; but, to write briefly, all I can say is that I was very proud to be there."

In 1943 rehabilitation became a fashionable subject in the public interest, and apparently the hospital had acquired a good reputation in this direction as they were invited by the Ministry to hold courses on the subject. Several were held for physiotherapists and some for doctors, and we tried to emphasise that rehabilitation was not a late addition to the surgeon's work, but concerned the whole hospital from the moment of the patient's admission, including the avoidance of unnecessary pessimism on the part of doctors or auxiliaries, the greatest degree of freedom of movement inside and outside the hospital, the provision of occupations and interests both in bed and later to encourage activity, as well as the more usually recognised technical methods, and—perhaps most fundamentally of all—by an understanding of the patients' difficulties and anxieties about many questions as well as his health. Here the almoner can be of great help, and Miss Ricketts has added the next few paragraphs about the work of her department:—

"The Almoner's Department, like most others at Orpington, had to be built up from nothing, beginning with the taking over from the A.P.A.O. the completion of the assessment forms for all civilians on the E.M.S. side, solving the problems of the speedy supply of appliances, finding convalescent vacancies, arranging special transport for those patients unable to travel by the usual methods, and finding answers to the numberless trivial difficulties that arose. The work has grown with the years, with peak periods when air-raid casualties were admitted, bringing with them a multitude of queries concerning homes, clothes, injury allowances, messages for relatives; and, later, convalescence, transport, travel, etc., quite apart from the work involved at their original reception.

"During the last couple of years there has been a steady and increasing flow of Service men discharged from the Forces while still in hospital, and the work concerning their rehabilitation has equally increased and produced its own problems. All these cases have to be referred to the Ministry of Labour—and Mr. Fowler, of that department, has been most helpful and has managed to place most of the disabled men in suitable work—and to many other bodies who all take an interest in them."

This leads on naturally to the help received from the Red Cross, the W.V.S., and from many outside agencies. One cannot complete the story without expressing thanks to these and to the many friends the hospital has made in Orpington, Bromley and Chislehurst for their help, whether it has taken the form of personal service or of gifts in kind or in money. From June, 1940, onwards the Red Cross has provided never-failing help of many voluntary workers, with the widest variety of jobs, from finding billets for relatives of the seriously ill to helping the discharged soldiers with home and employment problems. Their help materially has been equally varied, providing comfortable chairs and games and an almost incredible number of cards and cigarettes.

The Red Cross library has been particularly valued. Naturally the library provided for inmates of seventy or eighty was not very suitable for soldiers, and, after a hesitating start when no one seemed able to stay long as librarian, Mrs. Wimpey has given us the greatest help, taking her very welcome book-trolleys round the wards several days a week. For the year ending June, 1943, they issued over 36,000 books, about one-tenth of these being from the more serious part of the library. For a long time now the average has been up to 1,200 books a week. We have also had a small working party who have bound and repaired the books.

I could almost write an article on visitors to the hospital—two Ministers of Health, the Parliamentary Medical Committee, Ministry experts of every description from dieticians to physical training enthusiasts, County officials from accountants to A.R.P. instructors, and, of course, the Architects and Building department and the regular Visitor of the Governing Committee, and officers of every rank from the G.O.C. London District to the Army educational corps, and last but not least, representatives of many bodies anxious to help the service patients. Some weeks much of the time of the Medical Superintendent was taken up with talking to these visitors and taking them round. Many of these visits were of great value, but I sometimes wondered what staff and accommodation would be needed if the views of each separate expert were to be carried out in full.

One or two more episodes of the last stage of the war seem worthy of mention. In May, 1944, instructions were received to discharge as many patients as possible and to reduce admissions. The convoys from Guy's were stopped, but it was impossible to reduce military admissions much, as the demands were as great as ever. However, by D-Day (June 6th) our E.M.S. population had been reduced from about 700 to about 550. In earlier plans we had hoped we might be one of the receiving hospitals, but owing to the lines of communication chosen, this was not feasible, and it seemed as if our work would be less rather than more, our staff being taken away as mobile surgical teams. The need for these proved less than had been expected, and D-Day passed with little immediate effect on our work, though a few casualties from France trickled in from various sources. In view of later developments it was not till early October that we began to receive a steady stream of casualties from France, though, of course, many who came then had been wounded long before.

Early one morning in June we were surprised to have several short alerts, and to hear that planes had been brought down in many parts of London ; later we realised that this was the start of the flying-bombs. It was an unpleasant period at Orpington. It produced a surprisingly small number of casualties from the immediate locality, but on June 16th we had our first flying-bomb casualties transferred from Guy's, and on subsequent days several others from Guy's and from the southern fringe of London ; seventy-five were admitted during the rest of the month. Many of the " lines " went over or very close to the hospital. One was rather high and directly over ; another rather lower, passed just across the railway and was visible from the office window ; and a third, very low, seemed unpleasantly close to the bedroom window of my billet. Many people found them more unpleasant than the " blitz " ; even when no change of course or sound gave any indication of danger to oneself or to the hospital, the certainty that it was coming down somewhere in London gave one an unhappy feeling for others. Often, as they came down soon after passing, one could see the smoke and dust rising from an episode in Bromley or Beckenham or Chislehurst. The railway embankment was a great protection to the hospital, and sheltered us from any damage from two of the closest which brought us in many casualties.

At first we heard the guns in the distance as the flying-bombs came over Kent, and sometimes had the pleasure of seeing a Spitfire in chase as they passed over us, and, occasionally, saw one brought down in this way. Later, when the guns went to the coast, we had no such warning and the first sign was the very faint murmur, which could be almost felt as soon as it was heard. By then the balloon barrage had arrived and increased quickly. From the hospital field we could count many hundreds, and some of the balloons seemed over the hospital itself. If a bomb struck a balloon cable square, it appeared to explode in the air without doing any harm, but if the cable only caught a wing the bomb changed its direction and started coming down, often unpleasantly near to the hospital. One of the closest fell on the Chelsfield side ; as I ran up the corridor of the Old Block the passages coming from each ward was filled with clouds of smoke and dust, and I feared that at least one of the wards must have been damaged, but though many patients were buried in glass, we had no one injured. Living on the edge of the balloon barrage, which ultimately stretched for some miles, we developed great confidence in it as a protection, and have most unhappy memories of one afternoon when it was down because the wind was too strong, and flying-bombs seemed to be pouring over all afternoon and evening.

On August 2nd, 1944, I came up to the office after tea to find instructions that 256 patients were to be sent by ambulance train to Scotland at 2 p.m. the next day. The medical officers were called together and told to select patients, but the first list of the most suitable fell far short of the number required and lists had to be extended. After dinner the total numbers were getting about right and individual hard cases had

to be considered and final adjustments made. Then notes were brought up to date and abstracts made with the help of the office staff, who remained at work all night on these, and then started on the nominal rolls, etc. When I left about 2 a.m. all seemed to be working out satisfactorily, and the next morning could be devoted to organising the stretcher parties, blankets and equipment, etc., and deciding on the general arrangements for the ambulances.

During the early hours of the morning a number of flying-bombs came over, the last bringing in twelve casualties for admission. However, the cases were soon well in hand and the general evacuation arrangements uninterrupted. Certainly some of the patients welcomed the thought of their joiurney more than they had the night before. In accordance with instructions the following report was sent by Scott, who had been appointed entraining officer.

Loading at hospital began at 2 p.m.; ambulance train No. 301 was to berth at platform 2, Orpington Station, at 3.15. Actually it did not berth till 3.37. Loading began immediately and was finished at 5.47. Train left at 5.51, four minutes within the time designed by the Southern Railway. The entrainment at the platform was therefore completed in two hours ten minutes, the allotted period having been two hours thirty minutes. Great help was received from the station-master, Mr. Tucker.

At the hospital (in charge, Dr. Campbell) loading achieved by thirty-two students from Guy's Hospital, two light rescue parties of A.R.P. personnel and the hospital personnel available.

At the station (in charge, Dr. Scott) unloading of ambulances by four light rescue parties A.R.P. Loading on to train by R.A.M.C. detachment from Royal Herbert Hospital, Woolwich. All bearers must be congratulated on very hard, swift and successful work.

For a week or two after this there was plenty of office work in clearing up the complications arising from such a move, but for most of the hospital it was the most restful period since April, 1940. The hospital seemed almost deserted, especially walking up the open-air corridor of the New Block, where we were accustomed to see so many soldiers standing about talking, or on their way to the theatre or the massage department or occupational therapy. But, slowly at first and then more quickly, numbers began to rise again. On September 1st they were still 200; on October 2nd, 300; on October 23rd, 409; on November 20th, 511; and, early the next year, varying between 580 and 630.

About September 19th we heard the first rocket—a sound that was to become so unpleasantly familiar, but, strangely enough, those that fell locally in the earlier period, mostly fell in open country. It was towards the end that Orpington suffered most from rockets; and in March, 1945, for the first time during the war, the surgeons and house-officers were kept continuously at work in the theatres for two successive nights. After some of these rockets more local patients were admitted than from any other episodes, and far more out-patients attended for treatment than earlier on. (The first-aid post had been taken over by the hospital in 1943.) I remember especially one midday when a rocket fell in Orpington as the children were coming from school, and the hospital seemed to fill with them; fifty such patients were not easy to deal with here without warning, when doctors and others were already occupied, perhaps in the middle of an operation, and with no real out-patient department. But, luckily, most of their injuries were slight and not many had to be admitted.

Christmas, 1944, perhaps, reached our highest level of dramatic performances with the pantomime "Dick Whittington," with Sister Davies and Nurse Few in leading roles, and Mrs. Bevan (C.N.R.) as producer and performer. I was almost afraid that, like Miss Trant in "The Good Companions," the Matron would go off with the whole cast on tour. And so, without further outstanding episodes but with a steady stream of wounded from Germany, we reached "VE" Day. In spite of the short notice a wonderful dinner was provided in the Nurses' Home which all attended, and this was followed by a dance and a bonfire. When this gradually died away I was surprised to find an even larger bonfire at the other end of the hospital attended by those patients and others who thought, I suppose, there might have been some objection to their presence so late at the more official one.

Apart from the experience of watching and guiding the birth and growth of a large war hospital, it has been interesting to be in charge of so many soldiers in a civilian hospital. At first there was some tendency to an over-sympathetic attitude appropriate for the severely wounded, as after Dunkirk, but less so for the minor

dyspepsias, foot disabilities, and anxiety states of 1941 ; but this phase passed. Many of the soldiers in hospital at this period gave too unfavourable an impression of the Army, so that it was a pleasure to see a more representative cross section, say, on Charing Cross station or among the many admitted with fractures from football or motor-bike accidents. Later, one got an even better view of the best of the Army when the wounded from the fighting units began to arrive in large numbers.

It was strange how the dates of the major battles and more intense phases of fighting were reflected even in the small samples of soldiers admitted to one hospital such as this, and few battles from Alamein to the Rhine crossing failed to send their representatives here. As far as the civilian patients were concerned there was not, as a rule, anything special for the medical superintendent to do unless difficulties arose, but with the soldiers there were special problems with which some of the medical staff were less familiar, and I tried to see that questions of discharge from hospital, convalescent depots, leave, and medical boards, etc., were dealt with uniformly and fairly, with a common intelligible standard throughout all the hospital—not always an easy task with the different views of the different members of the staff. I think this helped greatly in making the men happy and contented here, and disciplinary difficulties have been few and far between. For a time, I personally saw every soldier in the hospital, then each soldier from overseas, and then as the numbers got too large for this, all the long-stay patients. In all these directions I received great help from my three successive military registrars—Major Philpott, R.A.M.C. (April 1940–June 1941) ; Major Mackenzie, Northumberland Fusiliers, attached R.A. (June 1941–April 1944) ; and Major Ashton, Northants. Regiment (April 1944).

(To be concluded.)

Do You Want to be a Doctor?

By "UNCLE HARRY."

DO you remember the old story about the young parson whose maiden aunt had been to hear him preach his first sermon ? As they were walking home after service she said : "James, dear, why did you go into the Church ? " "Because I was called, Aunty," he replied promptly. The old lady thought this over for a moment and then said : "Are you sure it was not some other noise you heard ? "

Every session at every medical school men—and women—who have "heard some other noise " enter as students. Some of these fall by the wayside and silently disappear. Some not so silently. Others tough it out somehow or other and get on the Register after a varying number of years. I remember one who took seventeen.

The first day we went on to dress for "Pom " (Jacobson, to you youngsters who never knew him), he looked at us for a moment as though we had just crawled out of a very mouldy piece of cheese before saying : "Gentlemen, if you have entered on the study of medicine because you think you are going to make a fortune, the sooner you change your minds and go into some form of commerce the better. Medicine is just as much a holy calling as the Church ; and unless you have a true ' vocation ' for it you will merely waste your father's money and your own time."

Every year in many households lads are pressed by parents to make up their minds what they "want to be." In some families both father and mother decide that they want to "make their son a doctor "—and Heaven help the man who is "made a doctor " against his will !

It would probably be right to say that the reasons for taking up the study of medicine, if not legion, are, at any rate, numerous. This, no doubt, accounts for some of those who fall by the wayside. For example, I have known quite a number of lads who have failed in the entrance examinations for the Services and think they have a chance by going in as a medical officer. This indicates a desire for a mode of life rather than for a profession, and it is not a sound reason. In peace-time the lot of a medical officer in the Services may be more or less what he likes to make it. It may be easy and pleasant with the minimum of work and responsibility, or it may be full of scientific and clinical interest with opportunities for specialisation and research such as can only be found at a teaching hospital or university. There are chances for all. Officers with what have been called "basic " qualifications, out of touch with professional subjects, have frequently shown an ability or even genius for administration and have attained high rank for that reason alone.

At the present moment it may be said that medicine is likely to go into the melting-pot, and nobody can say what form it will take when it emerges from the mould which

is being fashioned on the knees of the gods. Until then we shall not know whether we are to become salaried and supervised civil servants—as some hope, but others fear—who will be compelled to do the bidding of our lay masters and be debarred, as other civil servants are by their terms of service, from holding office as borough councillors and such like; or whether we shall be permitted a more or less limited amount of freedom. This would mean relegation to a condition of sub-citizenship which would prevent doctors from becoming, among other things, Members of Parliament. This should be borne in mind by those who seek an answer to the question which forms the title of this article, especially if they are not familiar with all the points at issue. They cannot know or even imagine how their futures may be affected until the National Health Act is on the Statute Book. Whether entries at the medical schools are likely to hang fire until this happens, I would not care to hazard a guess.

One thing is certain; many additional doctors will be required to operate the scheme, and it is more than likely that medical education may be State-aided. If so, those who pay the piper will feel that they have a right to call the tune, and there may be some kind of a selection board for students.

Unless the White Paper be radically redrafted, students should not count on taking a qualification to join a father in his practice, or to go into the Services or into any form of practice other than that to which they will be "directed." The "Authorities" will have the "power of direction" and newly qualified men will have to do the type of work and go where they are sent irrespective of their domestic arrangements, whether this may be institutional, or civil practice, or public health. If such direction happens to correspond with the individuals own wishes, he will be fortunate. No provision is made for "exchanges."

It is difficult for a student to discover his own special bent or *metier* until he has had some practical experience of the various branches of medicine and surgery. The wishful obstetrician may become a *de facto* general practitioner or *vice versa*. Selection for hospital staffs will depend more and more on academic qualifications and it will be from these that the possibly salaried consultants and the certainly salaried pathologists etc., will be selected.

Those who specialise in eye-work, ear, nose and throat, anæsthetics, endocrinology, clinical pathology, etc., etc., will certainly be required to take diplomas in their special subjects in addition to their registrable qualifications.

Probably 80 per cent. of all students are destined to become general practitioners. What the life of the future G.P. is likely to be, who can foretell? I imagine that it will be difficult for a G.P. to repeat the achievement of the late Sir James Mackenzie, and be translated from the ranks of general practice to that of specialism and research, if he is to be a salaried civil servant doing his eight-hour shifts at a Health Centre.

To qualify is an expensive business and up to the present there has been a discreet silence about remuneration. In this connection another "questionnaire" has recently been addressed to certain practitioners asking them to disclose the amount of their incomes *as returned to the Income Tax Authorities*. The object of this is plainly to find out the earnings of the G.P., and it should occasion no surprise if there is a certain amount of diffidence in replying.

Some parents may be excused for wondering whether, under future conditions their sons will be likely to receive an adequate return for the money spent on their education.

Not a few have expressed the opinion that with a controlled or conscripted medical profession will come the heyday of the quack and the "unregistered" practitioner. There may be something in this idea.

It looks as though the medical aspirant will have to consider many things in deciding on his future. Hesitation at the present stage of negotiations may entail loss of both time and opportunity. Nevertheless, some amount of hesitation will be understandable.

NOTE.

The above was written many months ago, before the Negotiating Committee had met the Minister of Health. In the course of the negotiations there were certain modifications in the White Paper. Since then there has been a change of government, and it would appear that the modifications have been more or less cancelled. The British Medical Association has published its "Principles," but in certain high places it is considered that terms of service for a National Medical Service can be devised within the framework of thw B.M.A.'s Principles which may render it unacceptable to the profession. Moreover, experience has already shown that the Minister is at liberty at any time to make an order which would modify profoundly any so-called "agreed" terms. This power might conceivably be used to the detriment of those doctors who accept aservice. In reading the above, it is necessary to bear these possibilities in mind.

"UNCLE HARRY."

Correspondence

A PROPOS RECENT ARTICLES, ETC.

To the Editor of the GAZETTE.

SIR, *A propos* recent articles, ballads and letters published in the *Gazette*, and lest a spate of mutual admiration continue to develop in your columns, it is salutary to remind ourselves that wars are fought by the combatant forces and not by the medical profession. For instance, I was under the impression that the Battle of Britain was won by R.A.F. pilots and A.A. gunners, just as the P.B.I., tank crews, sappers and, above all, the Royal Navy ultimately prevailed in other spheres.

However belligerent individuals may feel or may have felt, and however uninspiring the reflection, the main functions of medical officers in war-time concern hygiene (in the widest sense of the term) and morale. Incidentally, and curious as it may seem, I include war surgery under the latter heading. Having had some considerable experience thereof in the first World War and, quite indirectly, in the last War, I feel justified in making this observation, although to pursue the theme would defeat my own object in addressing you.

I am, Sir,

FRANK COOK.

12, Upper Wimpole Street, W.1.

OBSTETRIC SECTION LEAVING FARNBOROUGH.

To the Editor of the GAZETTE.

SIR,—May we be permitted to send through the *Gazette* a farewell message to the Obstetric Section of your medical School on leaving Farnborough.

For three years it has been our pleasure to work with the obstetric dressers and their teachers; and we have seen many students during this time. Not only have the dressers assisted us in our work, but they have contributed a great deal to the happy atmosphere which has prevailed in the department.

and their teachers; and we have seen many students during this time.

Not only have the dressers assisted us in our work, but they have contributed a great deal to the happy atmosphere which has prevailed in the department.

We shall greatly miss the ward rounds on Tuesdays given by Mr. McNair and his helpful advice on clinical problems. We remember well the Wednesday and Thursday visits of Mr. Blaikley, which, unfortunately, were brought to a close some months ago; and last, but not least, the regular Monday visits of Mr. Baker and the much too short period during which Mr. Cook was able to come here.

We are glad the link between Guy's and Farnborough has not been completely broken, as we shall still be receiving two dressers each month for practical experience. To those who have passed through this department we would say: Remember our motto "*Cave perineum arte non vi*" and we trust that to some extent we have contributed to their medical training.

We hope that to many of you it is only *Au revoir*, as you know that we shall be pleased to see you at any time and to hear of your progress.

We are, Sir,

J. J. HANDLER

THE SISTERS OF THE OBSTETRIC UNIT.

Obstetric Unit,
The County Hospital, Farnborough, Kent.

AN OPEN LETTER TO WRITERS OF SURGICAL TEXT-BOOKS.

To the Editor of the GAZETTE.

SIR,—As junior clinical students we humbly request that you read our letter with sympathy and consider seriously its plea.

We have just passed through the trying stage of learning anatomy, and had hoped, when reading our new surgery text-books, to construct our knowledge of this subject upon the basis of 2nd M.B. Anatomy. Owing, however, to the old-fashioned and very ill-descriptive terms still used in 1945 editions of surgery text-books, we find that it is not possible to further our study of surgery without first learning these old anatomical terms, which seems an unnecessary, as well as a useless, waste of time.

It seems that, in order for a few to achieve immortality, many others must suffer out of all proportion to achieve this end; and, as examples, we suggest that terms such as "Fascia of Zuckerkandl," "Cells of Kirschner" and "Cartilages of Santorini" are now out of date, and that their modern counterparts are infinitely more preferable in their descriptive powers and therefore in their ease of learning.

The study of anatomy has been rendered less arduous by the introduction of the recognised Birmingham Revision of the Basle Nomenclature to the modern anatomy text-books. We therefore dare to hope that you, as authors and editors of the modern surgery text-books, will be considerate and far-sighted enough speedily to follow this example, and to give the immortality of others a prolonged and, in some cases, a none-too-well-earned rest.

We are, Sir,

M. W. J. GRUMMITT.
And OTHERS

Guy's Hospital, S.E.1.

House Officers—Sector 10

FEBRUARY 1ST TO APRIL 30TH, 1946.

Remaining	*New Appointment*	*Transferred from*	*Transferred to*	*Retiring*
GUY'S. Allanby, K. D. Astbury, J. S.* Kinder, C. H. O'Keeffe, D.	Blundell, J. E. Buckler, F. R.* Cole, C. K.* Cormac, C. D.* Crook, J. C. Gardner, C. S.* Jenkins, J. T. M. C.* Leeming, J. A. L.* Lewin, D. C.* MacLean, K.S.* MacVicar, G.* Sidebotham, R. E. Stafford Clark, D.* Stewart, I. McD. G.* Topham, H. W	Shaw, J. F., from Orpington.	Montgomery, P.R. to Orpington. Neve, C. R., to Orpington. Roberts, C. G., to Southern.	Batty Shaw, A. Macrae-Gibson, N. K. Thomas, J. M. Thorne, M. G.
JOYCE GREEN. O'Connor, D. Porges, K. I.*	Bayliss, J. C. Lea, P. A. W.* Hallinan, W. M. C.			Morse, A. V.
PRESTON HALL. Lee, W. R.				
ORPINGTON.	Dixon, H. G. Parry, T. C. L. Wadia, R.* Walter, K. H.*	Montgomery, P. R., from Guy's. Neve, C. R., from Guy's.	Shaw, J. F., to Guy's.	Van Diggelen, H. Green, R. A. Barclay, R. F. Nicholson, D. P.
FARNBOROUGH.	Gethen Smith, E. B. Wilks, J. M.			
PEMBURY. Griffiths, J. E. King, M.B.	Cree, W. W. Shaw, C. S. Symonds, B. E. R.			Watford, N.C.J. Wallace, J. D. Walton, R. G.
SOUTHERN. Huntley, J. D. Jones, T. J.	Ward, M. W. P. Woodman, G.M.	Roberts, C. G. from Guy's.		Bensted, J.P.H. Breeze, D. G. Rudman, D. J.
QUEEN MARY'S. Fifield, J.				

* Ex-Service.

Sport

Rugby

GUY'S *v.* ROSSLYN PARK.

(*At Old Deer Park, Saturday, January 26th.*)

Result: Guy's, 11 points; Rosslyn Park, 11 points.

Guy's should have won this game handsomely, but after having much the better of the early exchanges they threw away their advantage in a reckless manner and may consider themselves fortunate in finishing level, Rosslyn Park scoring 1 goal and 2 tries to Guy's 1 goal, 1 penalty goal and a try.

There was little really good football, but as a struggle between two determined sides it was exciting to watch if only for the dashing forward play of the Park pack in the second half after they had lost D. Thrower, who was taken to hospital just before half-time. Guy's efforts to frustrate these raids were at times pitiful, but the Park's three-quarters were not sufficiently penetrative.

Guy's tries came as a result of dribbling. First Dwyer went over for an unconverted try and then D. Le Clus scored under the posts for Lewis to convert. It was during a rush leading to this try that the Park lost W. Thrower. Nevertheless, Guy's fell to pieces, and L. H. Cox, playing his first game on the Park's left wing, scored a try; two minutes after the interval the same player made a brilliant run to touch down under the posts, but an easy kick was missed. Guy's were playing so badly and the Park's forwards so well that it was no surprise when Waterkeyn crossed our line for a good try which he converted himself.

The game looked lost as far as Guy's were concerned, but in the closing stages a grand rally led to a penalty goal being kicked by D. Le Clus, and it was only a stroke of misfortune that prevented P. S. Carton-Kelly crossing.

GUY'S *v.* COVENTRY.

(*At Coventry, on Saturday, February 2nd.*)

Result: Guy's, 11 points; Coventry, 11 points.

A report appeared in the Coventry local paper saying that Guy's were probably the most improved side in London and that, on the return game with Coventry, they would run them to a far closer game than earlier in the season, when Guy's suffered a fairly heavy defeat at home. This statement proved correct and, further, in the closing stages of the game, it looked as if Guy's would win, but, with only three minutes to go, the Coventry right wing was just able to force his way over for a try in the corner.

Guy's kicked off against a fairly strong wind and, after some loose play in midfield Kenyon, the opposing fly-half, took advantage of the wind and kicked to touch just inside our "25." From a set scrum Hollins, the Coventry centre, broke through our line for a try near the post, which was converted. Guy's were not discouraged and fought well only to be driven back to their own line, due to the wind having a great influence on the kicking, and again, after a loose scrum, Coventry went over near the corner for an unconverted try.

Being eight points down—far from disheartening the Guy's side—seemed to spur them to greater efforts, and soon they were rewarded by a splendid run by D. Le Clus, who scored in the corner but failed to convert with a difficult kick. The try resulted from a fumbled pass by the Coventry wing, which Le Clus snapped up and, following a 40-yard run and a beautiful swerve past Pateman, the Coventry and England full-back, scored the first points. Excitement ran high in the Guy's team and soon after they were able to score again from another fine effort by Le Clus. Being hemmed in by Pateman after a short run, he kicked ahead and gathered the ball to pass inside to Owen, who forced his way over for another unconverted try.

After half-time the play was even with both sides attacking in turn. About the middle of this half Le Clus gave the forwards a chance to show their keen backing up with a cross-kick, which was dribbled over the line by the forwards for Le Clus to score a try, which he converted. The plan was now to hold Coventry at all costs. It was almost successful, but, with five minutes to go for "no-side," the Coventry right wing was able literally to barge his way through for the equalising points.

Le Clus was undoubtedly the outstanding three-quarter of the day, but credit must definitely go to the forwards, especially the two loose forwards, Eksteen and De Villiers, who kept Kenyon pinned down the whole time and were very dangerous with their clever dribbling. It is almost unfair to pick out players in this game because everyone in the Guy's team pulled his weight to produce this most encouraging result.

Association

GUY'S *v.* KING'S COLLEGE.

(*Played at Tooting, on Wed., Jan. 16th, 1946.*)

Result: Draw 3–3.

With a team considerably weakened by illness and injuries it was a fine performance for Guy's to draw this match. Although our opponents attacked relentlessly for the first five minutes, the game soon resolved into a hard, even, struggle. A strong wind caused many passes to go astray and, consequently, several promising attacking movements by both sides were spoilt. By a superb individual effort, in which he beat four opponents, Leckie gave Guy's the lead after thirty minutes. This was a great stimulus but, although play was keen, there was no further score before half-time.

After the interval play continued in the same ding-dong fashion, but within some ten minutes King's equalised. This was followed by a period of fruitless attacks by both teams in which it seemed that Guy's were slightly the better. A quarter of an hour from the end Leckie scored again for Guy's with a hard drive from twenty-five yards.

The lead was very quickly reduced and lost, King's scoring two goals in the following five minutes.

Guy's tried hard to equalise but it was not until the last minute that Leckie broke through and shot hard into the corner of the net.

J. C. Leckie deserves great praise for his splendid "hat-trick."

Team.—I. L. Busbridge; E. M. Newton; J. Robertshaw; M. J. L. Sykes (captain), H. R. C. Riches, F. Trist; J. Waller, A. E. Trist, J. C. Leckie, R. K. Foster, A. R. Merrill.

Hospital Information, etc.

Notices

FILM SHOW.

On Monday, March 18th, 1946, at 5 p.m., in the Physiology Lecture Theatre, the Association of Scientific Workers are holding a film show, which will include an address by Dr. Sutherland, of the Central Council for Health Education, on "Health and the Community."

INDEX TO VOL. LIX.

The Index to Vol. LIX (1945) is now ready for distribution and may be obtained free of charge from the *Gazette* Office or Wills Library.

RESIDENTS' BALL, MARCH 8TH, 1946

The Committee regret that no further application for tickets can be considered, the full number having been sold. It would be greatly appreciated if anyone unable to use their tickets would kindly return them at the earliest possible date to the Secretaries, Residents' Ball Committee, Guy's Hospital, S.E.1.

Pass List

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

F.R.C.S.

Primary Examination.

T. L. T. Lewis — G. A. Sechiari

Final Examination.

December, 1945.

L. Gillis — V. G. Patel
V. G. Griffiths — J. W. Spence
W. Hawksworth — J. Zimmerman
S. Muntarbhorn

UNIVERSITY OF OXFORD.

Bachelor of Medicine.

G. M. Woodman.

Examination in Pharmacology and Principles of Therapeutics.

December, 1945.

B. V. McEvedt.

Examination in Medicine, Surgery and Midwifery.

December, 1945.

T. H. S. Burns — G. M. Woodman.

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

December, 1945.

Surgery K. R. Brookes, *J. S. Gilbart, E. H. Osborn-Smith
Medicine K. R. Brookes, R. N. H. Vaun
Midwifery *J. S. E. Gilbart

January, 1946.

* Has now completed the examination.

CONJOINT BOARD.

FIRST EXAMINATION.

December, 1945.

Anatomy.

H. E. G. Dyer — D. S. Noble
S. S. Grove — B. Plant
A. J. N. Hage — R. D. Walsh
I. D. Jones — C. S. Ward
R. T. F. Larsen

Physiology.

A. J. N. Hage — P. B. Poole
S. A. Jolliffe — I. A. W. Scott

Pharmacology.

G. D. Banyard — J. L. Hardman
C. D. Bulstrode — R. W. Hughes
P. S. Carton-Kelly — F. L. Jackson
A. R. Ellerker — A. L. Jeanes
L. J. Evered — J. L. Jenman
R. French — R. H. N. Long
S. Balfour-Lynn

UNIVERSITY OF LONDON.

M.D. EXAMINATION.

December, 1945.

Branch I (Medicine)—C. J. Stewart

APPOINTMENTS.

UNIVERSITY OF LONDON.

Personnel of Internal Boards of Examiners for 1946. Second and Third Examinations in Dental Surgery.

Anatomy.

J. Whillis, M.S., M.D.

Special Anatomy, Special Pathology and Dental Histology.

H. L. Messenger, M.R.C.S., L.R.C.P., L.D.S.

Pathology and Bacteriology.

A. Bulleid, M.R.C.S., L.R.C.P., L.D.S.
P. A. I. Gorer, M.R.C.S., L.R.C.P.

Dental Surgery and Operative Dental Surgery.

W. E. Herbert, M.R.C.S., L.R.C.P., L.D.S.

Orthodontics.

R. E. Dix, M.R.C.S., L.R.C.P., L.D.S.

Surgery.

N. L. Eckhoff, M.S.

EXAMINERS FOR MEDICAL DEGREES.

Applied Pharmacology.

N. Mutch, M.A., M.D.

Forensic Medicine.

C. K. Simpson, M.D.
J. H. Ryffel, M.A., B.Ch.

Medicine.

J. J. Conybeare, M.D.

Obstetrics and Gynæcology.

F. Cook, F.R.C.S., F.C.O.G.

Surgery.

H. J. B. Atkins, M.Ch.

Papers by Guy's Men

Hudson, James A. Group Unity. *Brit. Dent. J.*, 1946, 16.

Thompson, Allan R. The Spring Bridge. *Ibid.*, 13.

Wenyon, C. M. Presidential Address. Tropical medicine in war and peace. (At the opening meeting of the 39th session of the Royal Society of Tropical Medicine and Hygiene.) *Trans. Roy. Soc. of Trop. Med. & Hyg.*, 1945, **39**, 177.

Coxon, R. V., and Another. Investigation into the efficiency of sulphadiazine in the treatment of malaria. *Ibid.*, 195.

Brockington, C. Fraser. The Unparented Child. *Public Health*, 1945-6, **59**, 53.

Barber, H. W. Benign lymphogranuloma of Schaumann with apparent involvement of the anterior pituitary. *Proc. Roy. Soc. Med.*, 1945, **39**, 92.

Forman, L. Reticulosis. *Ibid.*, 93.

Dowling, G. B. Non-diabetic necrobiosis lipoidica. *Ibid.*

Strang, R. P. (for Dr. L. Forman). Lupus vulgaris with miliary lymphatic spread. Epithelioma. *Ibid.*, 100.

Bennett, T. Izod. Hypertension. *Ibid.*, 59.

Ryle, John A. Socio-medical surveys. *Lancet*, 1946, i, 64.

Brock, R. C. Fractured ribs and other chest injuries. *Clin. J.*, 1946, **75**, 1.

King-Turner, G. E. Great opportunity to Reconstruct the Dental Curriculum. *Dent. Mag. & Oral Topics*, 1946, **62**, 259.

Lyon, H. J. Silent Friends. *Ibid.*, 264.

Harvey, Warren, and Another. Acceleration of the setting of zinc oxide cements. *Brit. Dent. J.*, 1946, **80**, 35.

Ogilvie, W. H. Surgical advances during the war. *J. Roy. Army Med. Corps*, 1945, **85**, 259.

Clarkson, Patrick, and Others. Treatment of 1,000 jaw fractures. *Brit. Dent. J.*, 1946, **80**, 69.

Dowling, G. B. Skin diseases of the foot. *Practitioner*, 1946, **156**, 104.

Hanby, J. H. Indications for chiropody, *Ibid.*, 112.

Sauer, F. D. A case of sarcoma of the liver. *Brit. J. Surg.*, 1945-6. **33**, 288.

Layton, T. B. Chewing as a therapeutic measure. *Dent. Rec.*, 1946, **66**, 36.

Cutler, R. Reflections on the development and general application of acrylic and conservative procedures. *Proc. Roy. Soc. Med.*, 1945-6, **39**, 103.

Glover, J. Alison. Acute rheumatism in military history. *Ibid.*, 113.

Payne, W. W. Nephrocalcinosis associated with hyperchlorœmia. *Ibid.*, 133.

Ellis, R. W. B. Trigeminal nævus and homolateral intracranial angioma associated with hypertelorism. *Ibid.*, 135.

Close, H. G. Tubercle bacilli in the pleural effusion of young adults. *Lancet*, 1946, i, 193.

The Services

AWARDS.

The undermentioned awards have been announced for gallant and distinguished conduct in North-West Europe.

O.B.E. (Military).

Colonel (Temp.) F. C. Miller, M.C., R.A.M.C.

M.B.E. (Military).

Major (Temp.) A. E. Loden, R.A.M.C.

Change of Address

R. R. Burn, Capt., R.A.M.C. (318375), 34 (Br.) F.D.S., B.A.O.R.

D. S. Hayton-Williams, M.R.C.S., L.D.S., 101, Banbury Road, Oxford.

C. Hewitt-Atkinson, M.C., M.R.C.S., 53, Green Street, Park Lane, W.1.

A. B. Kettle, Major, R.A.M.C. (246763), 31 (Br.) General Hospital, C.M.F.

J. F. Lockwood, M.R.C.S., L.D.S., 83, Wimpole Street, W.1.

W. G. Tillman, Lt.-Col., R.A.M.C., 93, Indian General Hospital, Singapore, S.E.A.C.

J. R. Trounce, Capt., R.A.M.C. (328918), 6 (Br.) General Hospital, B.A.O.R.

R. L. Waterfield, M.R.C.P., 20, Harley Street, W.1 (to 24th March, 1946). later 22, Harley Street, W.1. (Tel. Langham 4032.)

J. Wedgwood, Surg.-Lt., R.N.V.R., 1, Earls Terrace, W.8.

W. G. Gill, M.Ch., F.R.C.S., The Radcliff Infirmary, Oxford.

W. F. Hannay, M.R.C.S., L.R.C.P., 55, Harley Street, W.1. (Tel.: Langham 2422)

W. F. Roper, M.B., B.S., Medical Officers' House, H.M. Prison, Wakefield.

Births

JOYCE.—On February 5th, at Meyrick House, Bournemouth, to Nancie (née Dryden), wife of H. L. Joyce, S/Ldr. R.A.F., a son (Peter Stuart). A brother for Michael Richard.

WEDDUP.—On January 28th, 1946, at Mount Alvernia Nursing Home, Guildford, to Nancy (née Heathcote), wife of J. E. C. Weddup, Lt., A.D. Corps—a son.

SHARP.—On January 26th, 1946, at Guy's Hospital, to Hilda (née Palmer), wife of G. E. Sharp—a son (Christopher David).

Marriages

ECKSTADT—VAN MENTZ.—On Monday, February 4th, 1946, Edward Eckstadt, of Calgary, Alberta, to Denise Van Mentz, S.R.N.

EDWARDS—STUBBS. — On Saturday, February 23rd, 1946, at the Parish Church, Ashstead, Robert Logan Edwards to Jean Hazel Stubbs.

THORNE—POOLE.—On February 23rd, at St. Peter's Church, South Croydon, Martin G. Thorne to Dorothy Poole, of 18, Chichester Road, Croydon.

Deaths

FREIBERGER.—On February 10th, 1946, Israel Freiberger, L.D.S., R.C.S., of 2, Garrick Avenue, N.W.11.

BEVIS.—On February 19th, 1946, suddenly, Sidney William Bevis, M.C., L.D.S., R.C.S. Eng., 1, Beulah Hill, Upper Norwood.

HOVENDEN.—On January 31st, 1946, Arthur Cecil Hovenden, M.B., B.S., of Sheen House, East Sheen, aged seventy-six years.

JOHNSON.—On February 7th, 1946, at The Grange, Charlcombe, Bath, George Arthur Johnson, M.R.C.S., L.R.C.P., late of Cambridge.

PORTER-PHILLIPS.—On February 24th, 1946, John George Porter-Phillips, M.D., of 18, Walton Street, S.W.3, aged sixty-eight years.

SHAND.—On February 23rd, 1946, suddenly, William Shand, of Walden Cottage, Tadworth (Governor of Guy's, 1938).

EDS. {J.M.H. R.H.N.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LX No. 1504 *16th March 1946* *Ninepence*

PASSIM

THE Park—Guy's island of open space bounded on all sides by her buildings—is at present cold and bleak; no flowers bloom there; the trees are bare and the ground is muddy. We can blame Winter for the lack of flowers and for the bare trees, but not for the mud. For this is the direct result of the pernicious "short cut" habit which has developed among users of the Park within the last year. Where formerly grass enhanced the appearance of our "island," there now are to be found sordid muddy tracks bearing the imprint of hundreds of pairs of lazy feet. The protecting barrier of the chain railings has been stormed and, in places, the chains themselves now lie slack, broken and ground into the mud. These feet are the catalysts of a reaction which has been proceeding for so long now as to have become almost irreversible. The only way to rectify the catastrophe is to start the experiment again without the addition of the catalyst. Surely it is not necessary to stud the area with prim and nauseating little notices, "Keep Off the Grass"? We hope not. These would in any case have no effect without co-operation from everyone concerned.

Start the experiment again. Repair the chains; plant new seed; and let us take a little pride in watching the Summer bring back to the Park its pristine array of flowers, shady trees and green lawns.

THE lectures on "Social Pathology" and "Traumatic Aneurysm," delivered recently at Guy's by Professor Ryle and Mr. Sol. Cohen respectively, have provided very instructive and pleasant additions to our clinical teaching. Occasional "outside" lectures of this type have been delivered here in the past and have always been received with enthusiasm. The principle for which they stand is one which has been stoutly upheld previously in these pages. It is therefore both pleasant and satisfying to note that these lectures are part of a recently proposed scheme to invite, as often as is practicable, authorities from outside the Hospital to talk on subjects of medical and scientific interest. We look forward, therefore, to further outside lectures in the knowledge that our future visitors will be very welcome.

SIX hundred of Guy's men, women and their friends were gathered under a single roof on Friday evening, March 8th, 1946, when the Residents' Ball was held at the Dorchester Hotel. The occasion was a momentous one since it was the first of its kind since the pre-war days. There was a strangeness in seeing many familiar faces against the less familiar background of white ties and long dresses. This did not, however, prevent the evening from being a most enjoyable one. A great deal of the undoubted success of the function was due to the industry of the dance secretaries—Dr. Allanby and Mr. Attale—to whom thanks are due and should be rendered.

A NARROW win against Middlesex Hospital has brought Guy's into the final round of the Hospital Cup Competition. The final game is against St. Mary's Hospital, who again have a very strong team this season. The game, which will take place on Wednesday, March 20th, 1946, should be an extremely exciting one, and will no doubt have a large attendance. We wish the very best of luck to the team. It is hoped that Their Majesties the King and Queen will be present.

REPRINTS of "Orpington 1939–1945" will shortly be obtainable in complete form from the *Gazette* Office. There are also a few copies left of "Guy's and the German War."

Glaucoma

By FRANK W. LAW, M.D., F.R.C.S.

A Clinical Lecture delivered at Guy's Hospital Medical School on January 21st, 1946.

GENTLEMEN,—Glaucoma is a rather stereotyped subject, but a very important one, and you will forgive me if I present it again, considering it from the anatomico-pathological angle and from the point of view of treatment.

First, we must have a definition of glaucoma. It is a term given to a group of conditions which have one feature in common—namely, raised intraocular tension. The tension may not be palpably raised, but it is higher than the particular eye under consideration can tolerate physiologically.

> (*Mr. Law then proceeded to illustrate the anatomy of the angle of the anterior chamber, which he said played an important part in the pathology of glaucoma. It was formed in front by the corneoscleral junction and behind by the anterior surface of the iris, and the angle itself was filled by a meshwork of fine fibrils covered with a single layer of endothelium. He then continued*)

I shall give you a simplified and possibly slightly inaccurate basic conception of glaucoma. The theories of glaucoma are still theories. There are obvious aspects of glaucoma which I hope to present to you, but there is more in it than the production and drainage of aqueous. As, however, our knowledge of the other aspects of the pathology of glaucoma is obscure and possibly transient, there is no great disadvantage in omitting them for the present. Similarly, in the consideration of the production of the aqueous humour it is quite possible that some may occur other than from the ciliary processes and some absorption may occur at the surface of the iris, but it is likely that the production of aqueous is very largely carried out by the ciliary processes —gland-like epithelial processes over the ciliary body. It is equally true, though again not perhaps wholly or exclusively true, that the drainage of the aqueous from the eye takes place at the angle of the anterior chamber. The aqueous produced by the ciliary processes serves the purpose of nourishing the avascular ocular tissues—the vitreous, cornea and lens. It circulates through the fibres of the suspensory ligament of the lens into the posterior chamber, through the pupil into the anterior chamber, and then away through the meshes of the pectinate ligament so called, through the spaces of Fontana and the canal of Schlemm into the venous system, and there is a successive pressure fall in that direction.

I spoke just now of the theories of glaucoma. There are many manifestations of glaucoma in which it is clear and definite and proven that the angle of the anterior chamber is at fault. It is therefore permissible and even reasonable for us to allow our minds to go in the direction of blaming the angle of the anterior chamber in those instances of glaucoma in which the pathology is so far obscure. Various theories lead one into the realm of physiology and of physio-pathology, more particularly of the capillary system, and into the realm of colloid chemistry, of osmosis, of hydrogen-ion concentration, and so on. But until we know for certain it is quite reasonable for our purpose to admit their possibility and to concentrate on what we know more about, particularly since, so far, we have no medical or operative treatment directed to these kinds of glaucoma of more obscure origin. All we can do in the operative sense is to provide a drainage for the aqueous humour.

To touch lightly, however, on this side of the subject—a change in the hydrogen-ion concentration of the vitreous results in liquefaction or turgescence, and this latter state causes the suspensory ligament, lens and iris, which constitute a partition across the eye to be pushed forward. What would such a process bring about? The result would be a narrowing, possibly an occlusion of the angle, and so again we are driven back to the angle as the immediate cause of the rise of tension. Some vascular instability might result in a large increase in the effective bulk of the vascular tissue in the choroid, which is a very large capillary area. Again we have the increase in the tissues behind the diaphragm, the narrowing of the angle and the onset of tension. Therefore, while we do not know all about the more obscure cause of glaucoma it would seem wise at this stage to refer the ultimate cause of rise of tension to the angle of the anterior chamber.

I will now proceed to a simple explanation of one form of glaucoma—a hardening or thickening of the mesh-work at the angle resulting in rather more fibrous tissue and

rather less space, and therefore less "safety-valve mechanism" for aqueous passage. That is a state of affairs that can be seen under the microscope. The fibres increase in thickness as age increases, and the age incidence of glaucoma again provides corroborative evidence. Either, then, the spaces remain insufficient completely and rapidly to drain away the aqueous, resulting in chronic rise of tension, or the margin of drainage—if I may use the term—is so slight that some small upset, of the sort I have already mentioned, causing increasing bulk of tissues behind the diaphragm, is enough to tip the scale, and tension rises in this case acutely. Again, there are different clinical manifestations, fundamentally different pathology, but the angle is ultimately to blame.

Let me now turn to the clinical sub-divisions of glaucoma. Starting with the slightly more complex, but, I think, more easily understood, category, we will rapidly get the secondary glaucomas out of the way. If as a result—I am not giving you these categories in any particular order, and I do not pretend they are complete—of an iridocyclitis there is an exudative iritis which causes an adhesion of the iris to the lens all round the pupil, the passage of aqueous is forbidden from the posterior to the anterior chamber, but it is still produced by the ciliary processes, and the tension of the eye rises. An admirable demonstration of that theory of causation is given by the bulging forward of the iris seen in such conditions, called "iris bombé." Again, an exudative iridocyclitis occurs, filling the aqueous with fibrinous exudate which fills up the meshes of the angle, forbidding drainage, and the tension rises. These are not theories; these are the actual things that occur. A blow on the eye causes hæmorrhage, the anterior chamber fills with blood, the blood fills up the meshes of the tissues of the angle, and the tension rises. There is a blow causing a disorganisation without perforation, tilting of the lens, pushing forward of the iris against the cornea, and obliterating the angle; result, traumatic secondary glaucoma.

I just mention malignant melanoma—sarcoma so-called—of the choroid, which may be of enormous size and may cause a rise of tension and secondary glaucoma. Most unfortunately for our theories, the opposite sometimes occurs, and the eye becomes soft, but that is another story. Rise of tension may also be caused, not on account of the bulk of the obstruction, but on account of its position, causing the pressing forward of the diaphragm of the iris.

Having thus got rid of secondary glaucoma, which is easier of conception than some of the primary glaucomas, let us turn to primary glaucoma. I give it you in four groups. The first is congenital or infantile. It is not always manifest at birth, and so one has to add "infantile" to this otherwise convenient term "congenital." In such a case the young, plastic, distensile tissues, the sclera and cornea, are stretched by the increased intraocular tension, and so characteristically the young glaucomatous eye is enlarged. Hence the term buphthalmia, meaning "ox-eyed," which is given to the condition. It is often very simple indeed to point out the cause of congenital or infantile glaucoma. There may be a malformation of the tissues at the angle, giving one anatomically and physiologically no angle at all. There may be a congenital absence of the canal of Schlemm. Therefore we are again justified in referring the trouble ultimately to the angle.

The three remaining categories are varieties of adult primary glaucoma. We will take first chronic simple glaucoma, the result of raised intraocular pressure, which, as I have already said, may not be excessively or measureably raised, but is too much for the eye in question, and causes, by pressure, excavation or cupping of the tissues at the exit of the optic nerve. The pressure effect on the nerve fibres is such as to impair and then destroy their conductivity.

The next category is the acute, including the sub-acute, condition, occurring when, in the presence of the predisposing conditions which I have outlined, some precipitating factor, arising it may be in the vitreous or in the vascular bed of the choroid, tips the balance and causes drainage virtually to cease. The eye then immediately becomes stony hard and intensely painful.

Lastly, we have chronic sub-acute glaucoma. Here we have a clinical distinction of some importance even if sounding paradoxical. I have outlined the predisposition, and in the predisposed eye some milder precipitating factor may be repeatedly occurring—let us surmise increased vascularity of the globe through use or over-use—causing a slight rise of tension. Between the attacks the eye is normal.

Those are the four categories. We will now consider the effect not under four, headings, but under two—acute and chronic. This is not good enough for clinical

differentiation, but will serve when considering the effect. In the patient with acute glaucoma the eye is intensely painful. It is commonly described as blind, but there may be perception of light or even more. Vomiting is a frequent concomitant of the attack. On the globe the effect of such increased tension and stasis is virtually to stop the metabolic processes which are going on inside the eye, to its functional detriment—its permanent detriment if sufficiently prolonged. Clinically the eye is engorged and shows ciliary and conjunctival injection. It feels hard, the anterior chamber usually appears shallow, the pupil is commonly inactive, semi-dilated, and horizontally oval. The cornea is hazy, and that haze may be resolved into its cause by examination under a good light with the uniocular loop, when it will be seen to be due to a corneal œdema, such œdema being quite readily visible with a ×12 magnifier, and may even have gone on to bullæ formation in the epithelium of the cornea. Further, these bullæ may actually have ruptured and stain with fluorescine. The picture is really unmistakeable. The diagnosis is from iritis or iridocyclitis, and the difficulty is in a case of acute iridocyclitis with secondary glaucoma. It does not take very long for the vision to be permanently destroyed in an eye with acute glaucoma ; it may be a matter of days, but it is not many, and therefore interference is always indicated.

I turn to the effect on the eye of chronic glaucoma. With a slight rise of intraocular pressure above the normal physiological level the same process occurs ; the optic nerve head yields before the pressure, and the nerve fibres as they come sharply over the edge of the sclera become physiologically interrupted. Such an influence does not affect at first, or for a long time, the papillo-macular bundle, which clinically means that central vision is not affected until later, and this makes it all the more dangerous a disease, for the patient will notice a loss of central vision when he will ignore a loss of peripheral vision, more particularly when the peripheral loss is in an area of the field also served by the other eye. I need hardly remind you that the characteristic nasal peripheral loss, upper or lower, extends usually in an " opening fan " fashion on to the temporal side either above or below, and is often, if not always, accompanied by a para-central loss of visiual field of arcuate shape, which may link up with the normal blind spot. The loss continues, until the last and worst state consists in the retention of only a small temporal island of field and finally that is lost.

The subjective effects of chronic glaucoma must be subdivided. I am going to put to you the broad truth, not strictly accurate, but not in any case misleading, and therefore justifiable, that chronic simple glaucoma is a symptomless disease. The patient complains of nothing until he happens to notice his field loss, or, indeed, until too late. The patient comes up for a new pair of glasses or with a chalazion, or with any one of a score of different simple conditions, and because one is aware of the insidious nature of glaucoma one is not surprised to find that he does not suffer from pain or obscuration, he does not see haloes nor rainbow rings around the lights ; he is aware of nothing wrong indicative of serious disease. With the chronic simple type of glaucoma he enjoys a subjective normality. With the chronic sub-acute type the sufferer may see haloes round the lights and find his vision a little depressed and his eye not comfortable, but the attack passes off and the eye returns to normal. I cannot tell you whether during the attack there is any field loss—I should say not—but between the attacks there is certainly none, unless there have been attacks in such intensity and number as to make their aggregate effect sufficient to affect the field of vision.

You will thus see that the subjective symptoms of the chronic sub-acute group which I have given correspond to the usual textbook descriptions of the chronic simple type. The distinction, I assure you, is important.

I turn to the treatment of glaucoma, taking first of all secondary glaucoma, because secondary symptoms are transient manifestations arising, so to say, out of the conditions prevalent at the moment, and relief, for example, of the condition obstructing the passage of aqueous from the posterior to the anterior chamber will relieve the secondary glaucoma. If therefore by a mydriatic one can let the aqueous through, the glaucomatous condition clears up. If it is necessary to resort to iris puncture the condition again is relieved and the tension falls. Things are not quite so simple in the exudative type when the angle is occluded, but temporary relief can be given by paracentesis and anterior chamber wash-out. The treatment of secondary glaucoma naturally also involves the treatment of the cause.

The treatment of primary glaucoma we must consider under two headings—acute and chronic. The immediate aim in an acute glaucoma is to relieve the intensely high pressure. If such is not accomplished by medical means operation must be

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undertaken, which latter interference is best avoided if possible on the general principle that it is better not to operate on a congested, engorged, inflamed eye if this can be avoided. One therefore tries to influence the tension by the exhibition of miotic drugs —eserine, pilocarpin—together with the local application of heat (of which the best form is by the short-wave diathermy machine), the administration of saline purgatives on the dehydration principle, and the exhibition of morphia and such-like to relieve the pain. Frequently the tension is brought down to normal or nearly so as a result of these measures, enabling the eye to settle down, to become white, and to be submissible to the operation for chronic glaucoma.

How long can we give it? We cannot generalise, but in hospital, if the case is received within a few hours of the attack, one can give it safely twenty-four or forty-eight hours' attempted medical treatment. The alternative, if there is no response, is the reduction of the pressure by operation. This takes the form of a broad iridectomy, which relieves the tension immediately by the simple act of puncture, but also permanently by reason of the fact that the iris by this broad iridectomy is torn away at its root over a considerable area, opening up once again a portion of the angle of the anterior chamber.

We are left with the treatment of chronic primary glaucoma. It is correct to treat the chronic sub-acute type as acute in the acute attack, and as chronic in the intervals. It is permissible to put them on to eserine or pilocarpin 0.5 or 1 per cent., twice or three times a day, which has the effect in the majority of cases of keeping the tension within bounds for the time, and it is necessary to assess the permanence of the value of this medical treatment by careful and repeated examination of the visual field. There are instruments to measure the intraocular pressure which are of doubtful accuracy and doubtful value, and, to my mind, there is a considerable danger in unskilled hands in these procedures, because entirely false impressions might be left on an unskilled observer as to whether the eye should or should not be operated upon if the decision were based on tonometric readings in so-called millimetres of mercury. One cannot say whether the pathological cup is any bigger after a fortnight. The estimation of the tension with the finger-tips is not good enough. But one can see in a very short time minor changes for the worse after repeated examinations of the visual field with the same size and colour of test object.

If the patient is losing ground in spite of miotics, there is no justification whatever for leaving the eye until fixation is gone or even until the scotoma, paracentral or peripheral, has got so near to fixation that vision is awkward. In such a case the patient has to take your word for it that the condition is worse, and that it will be necessary to attack by operation; and if he is wise and you are honest he will trust you.

The operative technique need not detain us. The object of it is to provide a filtering cicatrix which does not yield, and is usually covered by conjunctiva. There are many operative procedures, from which it may be deduced that no one operation is always satisfactory. There are trephines, sclerectomies, sclerotomies, operations in which a piece of the iris is drawn up into a hole through the sclera in order to provide an epithelial wick to prevent closure, and there is an operation which attempts to drain the aqueous into the suprachoroidal-lymphatic space, known as cyclo-dialysis. Whatever method one uses the idea is to provide a drainage for the aqueous. In the event of a successful result, which is by no means infrequent, the permanemcy of the relief is such as to drive one's mind back once again to the conviction that whatever the fundamental pathology, the ultimate relief caused by providing an alternative drainage bed for the aqueous compels one to believe that aqueous drainage is fundamental in the pathology of chronic primary glaucoma.

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Orpington, 1939-45—Part IV

By VARIOUS AUTHORS

ORPINGTON has not been a great medical centre, but there has been enough for Vertue and Hale-White to give regular teaching rounds, and, of course, in any hospital of this size there must always be much of medical interest. We have had our share of tropical disease (one morning by chance I wrote specialist reports on three soldiers from Palestine, Abyssinia and Burma) and some very successful cases of amœbic hepatitis. In 1940–42 we were able to help by holding the clinical examinations for the London M.B. here, and had at that time quite an adequate number of cases. It has, however, been more a centre for surgery and surgical specialties,

especially orthopædics ; and Scott and Batchelor have written about these, and Stamm about the nerve injuries for which we became a centre late in 1944. In conclusion, after these more serious contributions, Scott has added a short account of the Mess, and Vertue of some other social activities of the hospital.

SURGERY AT ORPINGTON.

By E. A. Scott.

We have had six years of surgery under most diverse conditions. On our arrival, although officially ready to accept air-raid casualties in astronomical numbers, we had neither operating theatre nor equipment. But an operating theatre was produced out of a bath-house, and a theatre sister's room out of a barber's shop, previously used as such by the inmates. By the skilful planning of Bromley, who was at Orpington the first few weeks, and the indefatigable cheerfulness of Sister Dorothy Smith, a really efficient unit was produced, which has, in fact, proved to be one of the most comfortable arrangements for operating in which it has been our lot to work.

Two tables were now equipped by the gradual arrival of instrumentarium, which included two Boyle gas, oxygen, chloroform, ether, anæsthetic machines of the latest pattern. These were lovingly and carefully unpacked and assembled by Scott, who was frustrated at the onset as Kilpatrick performed the first operation for empyema under local analgesia on October 19th, 1939. This was rapidly followed by a cystoscopy by Doherty (with his own cystoscope !) on a man from Derby, who has made us regular return visits for diathermy of a papilloma. In desperation, Kilpatrick, looking for more surgery, penetrated into the fastnesses of the P.A.I. wards, and found an aged gentleman with a strangulated hernia, who attributed his entire trouble to being issued with a nightshirt which fastened up the back ! Operated on under spinal analgesia with gratifying complete recovery. General rejoicings.

Gradually an increase in surgery occurred. Sister Smith had by this time a splendid routine in working order, and the surgical work and arrangement was smooth, and tea was served at regular and short intervals throughout the day. Every succeeding theatre sister has kept up this tradition, and any locally stationed officer knew exactly where to come when visiting the hospital for any purpose, surgical or social ! May, 1940, had arrived and with it the overwhelming rush ensuing from the evacuation from Dunkirk. Luckily we had by then been able to open the New Block whose theatre was equipped for three tables, making five in all in the two blocks. The ten days following was a vivid reminder of 1918. But never had we expected such work on untreated casualties straight from the field, which we had to face within fifteen miles of Charing Cross. Again we had been lucky, for a most welcome surgical reinforcement had reached us, to replace Kilpatrick, in the person of J. T. Laurenson, from New Zealand. He has contributed much sterling work for over five years. In former days he played lawn-tennis for New Zealand in the Davis Cup *v.* Australia, and his surgery has consistently been on the same high plane. Also his unfailing cheerfulness in all circumstances of underwork, overwork, and danger has been an inspiration of the highest order. May he remain much longer !

Our work now underwent somewhat of a change, as various special departments developed. The New Block undertook an orthopædic aspect. In the Old Block there arose a genito-urinary department under Doherty and a gynæcological one under McNair. In November 1940, Cann joined us and has had about as many E.N.T. beds (but not, of course, as large a turnover) as his department at Guy's in peace-time, and has conducted two busy military out-patients each week. How valuable these special units have been to Guy's in their dilemma during air-raids is evident by the fact that, for instance, Doherty has been able to maintain a unit of anything between forty and fifty beds for genito-urinary cases alone. In the latter part of the war the distribution of the 676 E.M.S. beds was approximately as follows :—medical, 90 ; surgical, 146 ; orthopædic, 300 ; peripheral nerve injuries, 40 ; ear, nose and throat, 30 ; gynæcological, 25 ; and genito-urinary, 45.

The R.A.F., particularly in 1940–42, was very near us owing to the proximity of Biggin Hill, then one of the busiest of fighter stations and the most successful in knocking down the Hun. The officers' ward was largely inhabited during 1940 and 1941 by casualties from above, in the persons of the fighter pilots to whom we all owe so much. We felt it a great honour to be able to contribute to their welfare.

As the war progressed and the method of air attack altered, our work varied and was more dependent on the proximity of the landing points of flying-bombs and rockets.

If very near we were at the highest pressure for hours on end. But through all this the routine work went on and never were we other than full to capacity. To find beds for sudden emergencies was always a problem.

Since the collapse of Germany and then Japan we have seen little or no decrease in work. Our orthopædic cases, sent largely to be near their homes, are long-stay cases. The amount of work which has been got through during six years can be realised from the fact that we have already had no fewer than 23,924 cases in the two theatres up to date (November 20th, 1945), which averages seventy-five a week. Four medical officers have achieved the Diploma of Anæsthetics in that time—Hawkins, Brian Johnson, Willshire and Stevens; and we are given to understand from the surgeons that the anæsthetic level is high. There has been only one death actually in the theatre, and that was not attributable to an anæsthetic cause. Looking back on the past and the origins of surgery here, it sometimes seems impossible that such good results could have been achieved, and actually such results are, in fact, a first-class tribute to private enterprise in the form of the voluntary hospital and its attendant medical school, out of which came all the medical and nursing staff who contributed to the venture.

ORTHOPÆDICS AT ORPINGTON.

By J. S. Batchelor.

The work of the Orthopædic Department has varied with the stages of the war, and can be divided into three phases. In 1940–41 we were largely concerned with the treatment of air-raid casualties. In 1941–42, the period of reconstruction, we dealt with a large number of injuries sustained by Service men in training. Later, in 1943, we began to get wounded from abroad, many of whom required reconstructive surgery. Some purely orthopædic civilian cases have been treated throughout, and these have increased recently.

In 1941–42 our cases fell into three groups—knees, feet, and fractures. At one time, before we had properly adjusted our ideas to military surgery and learnt the art of "disposal," our wards were flooded with soldiers with painful feet. The late Mr. Lambrinudi pointed out, quite rightly, that the foot that had broken down under the rigours of military training required rest—not exercising or "working up," as the treatment was commonly but thougthlessly described. All who knew Lambrinudi will recall the zeal and enthusiasm with which he put his ideas into practice and we soon found ourselves overwhelmed by the foot problem. We learnt that hallux rigidus and valgus and hammer toes rarely required operation in a serving soldier and that for most painful feet recategorisation was the correct procedure. Lambrinudi recognised, however, one type of case for which rest and physiotherapy were essential—soldiers, usually young, with acute foot strain of relatively rapid onset characterised by pain in the forefoot with spasm and tenderness of the intrinsic muscles. He pointed out that these cases, if not correctly treated in the early stages, would quickly develop secondary deformities, particularly contracture and clawing of the toes.

In the treatment of a large number of knee injuries two important facts came to light—firstly, the frequency of cruciate ligament injuries, and, secondly, the importance of adequate rest to the joint after meniscectomy. No less than 30 per cent of the knee injuries treated have had tears of the cruciate ligaments. Tears of the collateral ligaments, on the other hand, have occurred in only 5 per cent of our cases. It is easy to account for this disparity, for the chief function of the cruciate ligaments is to stabilise the knee in flexion, the position in which most knee injuries are sustained. The collateral ligaments, on the other hand, are damaged only when when the joint is extended and injuries to the knee in this position are not common. Old cruciate ligamentous injuries were a frequent cause of confusion in diagnosis, for the resulting instability can produce symptoms closely mimicking the internal derangement of a torn meniscus.

The importance of a full ten days' rest after meniscectomy, during which time quadriceps exercises only are performed, was soon appreciated. We also learnt that the treatment of the chronic synovial effusion was essentially prophylactic; that it could be prevented by keeping the man with the swollen knee in bed, rather than by irritating his inflamed joint with physiotherapeutic stunts and new ideas in rehabilitation. As the war progressed we have been content to rehabilitate our knees more and more gradually, and we are satisfied if an internal meniscectomy is fit for discharge in 5–6 weeks, an external in 6–7 weeks, and a cystic external cartilage in 7–8 weeks.

Most fractures at this stage were caused by injuries during training. The femur, tibia. and bones of the ankle joint were most commonly affected. For the most part fractures have been treated on conservative lines, although at one time we developed an enthusiasm, fortunately short-lived, for internal fixation, which was given a trial in fractures of the tibia and femur. Although the minimum of splintage was used and every effort made to encourage early function and joint movement we were not convinced that these operations accelerated recovery. We are satisfied that the best results are obtained by the careful use of strictly conservative methods which, if properly carried out, need not be followed by troublesome joint stiffness. Internal fixation with plates and screws is reserved for certain injuries such as fractures of the femoral neck and trochanter, unstable fractures of the tibia, radius and ulna, diastasis of the ankle joint, and fractures of the internal malleolus.

We have been most impressed by the important part that nutrition of the limb plays in promoting union. When the limb is "dead" the fracture unites slowly. Many fractured tibias have been transferred to us, months old and ununited, and when the plaster is removed a shrunken limb with dry scaly skin, wasted muscles, and stiff joints is revealed. Often prolonged immobilisation produces a vicious circle with progressing lowering of the nutrition and delay in union. Limb nutrition largely depends on muscle action and this can be maintained by making the patient exercise his muscles under the plaster. To get the best results, enthusiasm on the part of all including the patient, is essential. Continuous encouragement, cajoling and even bullying is necessary. Rehabilitation starts the day the patient is admitted and by means of individual treatment, ward and class exercises, physical training and occupational therapy, the patient and his injured limb are kept alive and happy. We have been fortunate in having an excellent and comprehensive rehabilitation service organised by Crisp and we have appreciated the efficiency and enthusiasm of the Massage School and students, who worked here for most of the war.

The problem of the fractured scaphoid in the Service man has been with us throughout. It is strange how often the true nature of a wrist injury is missed, despite all the propaganda on this subject. We are convinced of the importance of immobilisation with the hand in full radial deviation. In this position most fractures of the scaphoid join readily—at a speed comparable with the rate of union of other fractures—and even when the diagnosis has been missed and absorption of the fractured surfaces has commenced, union can often be obtained in a reasonable time without grafting.

The wounded transferred to us in 1943 had been treated by the accepted closed plaster technique. The initial treatment had clearly been carried out with great efficiency, for most wounds were covered with clean granulations, and troublesome bone infection was uncommon. By the time they reached us, however, the closed plaster treatment had fulfilled its function. Unnecessarily prolonged immobilisation in plaster of the limb with a granulating wound often produced delay in epitheliasation, extensive skin soreness, and muscle atrophy. We placed these limbs in posterior plaster slabs, from which they were removed daily in the ward for "limb toilet." If union was not sound they were at the same time measured for a walking caliper, which we found useful at this stage for fractures of the tibia as well as the femur. The astonishing acceleration of union that this routine sometimes effected can be attributed to improvement in nutrition of the limb following removal of plaster and restoration of function.

With the introduction of penicillin in 1944 the change in the character of the wounds was remarkable. Instead of granulations with surrounding fibrosis, we now found firmly healed supple scars, and so we have been able to proceed with reconstructive surgery much sooner. Until comparatively recently onlay grafts of tibial cortex, fixed in position with screws, were used as a routine, but cancellous bone-grafting has provided us with a new and effective method of wide application. The cancellous chips, cut from the wing of the ilium, are highly osteogenic, and their viability, even in the presence of infection, makes grafting possible in circumstances that would spell certain disaster for a cortical graft. The technique is simple, requiring no elaborate armamentarium or complicated carpentry.

Such are some of the thoughts brought to mind by reflection on the work during the past five years, when some thousands of Service cases have been dealt with. We have been assisted throughout by the co-operation of our Medical Superintendent, Dr. Campbell, who, although a physician, has always shown great patience in handling our orthopædic problems, of which he now has, I believe, a very real understanding. Many of us feel that a medical service, organised and administered on lines similar to those we have enjoyed here, would soon become popular.

PERIPHERAL NERVE INJURIES.

By T. T. Stamm.

In the autumn of 1944 I was asked to visit the P.N.I. unit at Oxford. On arrival I found that it had been decided that a unit for these cases should be established at Orpington and I was to be the unfortunate surgeon in charge—I say unfortunate, for P.N.I's have always had the reputation of being disappointing and tedious cases to deal with. However, three days at Oxford helped to dispel some of the gloom and did give us a plan on which to organise our unit, though we wondered how far the absence of the elaborate methods that had been developed at Oxford for research purposes might affect our treatment and our results.

Cases soon began to arrive, at first in a trickle but soon in such a flow that we twice had to stop admissions to catch up with the work. For the first four to five months we plodded steadily on with nothing to show as far as the surgical side was concerned. We soon, however, began to see a great improvement in the general condition of the affected limbs, and this was entirely due to the enthusiasm with which the physiotherapy department organised their side of the treatment. This first period was rather like gardening in winter—lots of work and nothing to show for it. At last, however, after what seemed to be rather a late spring we began to get results. The effect on the general morale of the patients, when first one and then another found that they could contract a muscle that had been paralysed or begin to feel a return of sensation, was astonishing. We had feared that loss of morale might be a serious trouble with patients who had to be in for such long periods with little apparently happening. In fact, we have had less trouble of this kind amongst our nerve injuries than in other classes of patients.

We have now been running for a year. During this period we have had 119 in-patients through the unit, and have performed 32 secondary sutures. It is not yet possible to assess end results, but so far we have only had one case that has not shown signs of recovery " on time." It is, however, possible to give our impressions so far. The supreme importance of adequate and enthusiastic physiotherapy at all stages of treatment is vital. At Oxford it has been shown that galvanic stimulation of paralysed muscles can maintain them in a healthy state until their nerve supply is restored. To be effective, however, this treatment must be given at least three times a week to each *individual* muscle for three minutes. This by itself entails much work. Equally important is treatment to maintain the nutrition of the limb and to prevent stiffness of the joints and contractions. With adequate early treatment it is possible to maintain the whole limb in a healthy state without stiffness, contractures, or much muscle wasting, so that if the nerve recovers there need be no ultimate disablement. So often, however, the loss of function of the nerve itself is only one disability, for the muscles it should control have wasted away and the joints have become fixed. This is the one depressing feature of P.N.I's, and my advice to all those dealing with such cases in the first place is: do not bother about the nerve: that can be dealt with later: devote all your attention to maintaining the health of the rest of the limb.

It is also important to segregate long-stay cases of one type together. Each patient has to wait a long time before he can appreciate any benefit and is liable to get " browned off." No treatment is ever effective if the co-operation of the patient has been lost. If he can see his fellow-patients finally making a good recovery and can share their surprise and excitement when some muscle once more begins to function, he will remain full of hope himself, especially if there is a general feeling of enthusiasm amongst those who are treating him. Our results at Orpington have far exceeded our expectations, and I am satisfied that this has been due in the main to the grouping together of these cases and to the enthusiasm of the physiotherapy department and of their medical officer, Dr. Holloway.

To sum up: our early fears have been found to be quite unjustified. The treatment of peripheral nerve injuries is a fascinating subject, giving results that, on the whole, fully justify the time and trouble that they entail, but they do demand enthusiasm and good organisation if the best results are to be achieved.

SOME SOCIAL ACTIVITIES AT ORPINGTON HOSPITAL.

By H. St. H. Vertue.

One method of dealing with the social life of Orpington Hospital would be to paint it like a picture with artistic sincerity, the hospital being in the foreground, and Orpington itself together with some few relevant aspects of the War making a com-

posite background. Artistically, this would be the best method, but one might say that there were three main directions in which these activities lay—the domestic hearth, the Mess and the women of the hospital. Permanent homes among the staff were few and the sum of the efforts of those fortunate enough to have them was small, though their owners were able to make many friends. The Mess is receiving attention from another hand. It is the women of the hospital who require a little notice.

First and foremost comes Miss Marriott, the Matron. She must have seen from the time she took office that the hospital needed what one can only call a soul of its own. To perceive this in a vague way would not be beyond many persons' powers, but to grasp the idea firmly and to put it into execution required more character. But Miss Marriott also saw what no common mind would be able to, that a culture was needed as well. No doubt she was influenced in all this by consideration of the needs of the young nurses in her charge. Some of her many activities can be touched on. There were plays of many sorts, ranging from pantomime to a Nativity play, from hilarious levity to extreme solemnity. There were debates in the Nurses' Home and there were literary evenings. One of the latter, at which the Vicar of Green Street Green was prominent—was particularly successful. There were Brains Trusts, sometimes better than the official, because freer from their characteristic heavy respectability and general vague benevolence, and sometimes worse, because the young performers had not time to gather a store of knowledge. Then there was an evening of recounted experiences by nurses who came from abroad, which proved very interesting.

Lastly, there was music. Early in the war Dr. Scott started giving gramophone recitals and he still sometimes favours us, but the practice was greatly extended by Miss Barnes. They are held in the Matron's drawing-room and the walls and floor are draped with nurses, all come to drink the pure draught of Helicon. For nothing but the best work of the best composers is ever played. A great deal is owed to Miss Barnes for letting us have such a quantity of pure and beautiful music. There is only one matter in which Miss Marriott's taste and the writer's seem a little at variance, and that is her liking for community singing. Perhaps, if the singers could ever be made to mend their pace above *Lento lugubre* it might be less heart-breaking ; but they never can. All these evening entertainments would have been more difficult if the nurses had come off duty later than 8 p.m.

There have also been dances at which Dr. Campbell has been an assiduous attender —a fact that is well known to be much appreciated. In her schemes for social activities at Orpington Miss Marriott has been fortunate in Dr. Campbell's attitude. He has taken an active interest in nearly all these things, an urbane chairman of Brains Trusts, or one ever ready at any entertainment to introduce the performers or send them on their way with a neat speech of thanks ; though not, strictly speaking, fond of classical music, he has enjoyed many of the concerts. It is not good for men and women always to get their music by turning a knob or changing a record; and therefore Miss Marriott has been quite right in making the nurses get up concerts among themselves. The standard of performance has been higher than one would expect. None that heard Nurse Few or Nurse Smith sing will forget them.

Among the sisters Sister Dornan takes first place—the soul of hospitality and kindness. In promoting a good spirit in Orpington she and Miss Marriot have been to some extent complementary—the one with domestic, and the other with cultural ardour. In attaining the same end the sisters have done as much as anybody, and more than most. It is not the place to describe the way in which they have maintained the highest standard of nursing or the tradition of etiquette, but it is right to mention their unfailing liberality, kindness and courtesy. To say more would be outside the scope of this short note. Sisters ought to be celebrated in verse.

THE MESS.

By E. A. Scott.

Our medical officers' mess is one of the best, if not the best, we believe, in the Sector. Starting from very humble beginnings in the Nurses' Home laundry-basket room, it has reached a degree of comfort we all greatly appreciate.

We have had a series of splendid fellows resident, and though comparisons and distinctions are invidious, it is impossible to avoid recalling such men as Budd, Hawkins, Silas Clarke, Manning, Fung, R. A. and B. D. Johnson, and Hammond—to name only a few. In addition, we have welcomed with open arms the South African con-

tingent in the persons of Van Steytler, Halamandres, Albers, Paul Large and, most recently, Van Diggelen. Philip Evans, after joining the Navy, distinguished himself by winning the George Medal, much to our pleasure. We regret greatly our losses in Gussy Cuthbertson and Cross—killed on service at sea—and the severe wounds sustained by Peter Swift. Mike Mullins, too, although not a resident with us, was so frequently at our parties with his wife that his untimely death in Italy hit us all very hard.

At one time (1940–42) we had Hale-White and Batchelor in residence, and they both added entertainment and social lustre to the membership. Latterly the Mess has been reinforced by our Military Registrar, Major Ashton, and this close association has produced a remarkable liaison between military and civilian authority: we can remember no occasion of difficulty between us.

We have, as far as possible, retained the Guy's tradition of "going-off dinners" whenever our house-officers have been on the point of leaving. Speeches abounded at these ceremonies, and never shall we forget the moment when B. J. Fowler, in answering his toast, said: "I am about to leave you," and did so backwards over a fire-extinguisher, and disappeared through a door into an adjacent room! To our dances sisters and nurses came and came again, and we cannot help referring to the aid on these occasions that we received from Sister Betty Heap and Sister Dorothy Smith, always in the centre of the social whirlpool; they always made the thing go.

We used to play darts a lot at one time, but billiards has also called us from time to time, with an intervening period when model railways, owned and laid down by Hammond, held the floor. To Scott their removal has always been a sad moment, though other people held other views. We like to think that, scattered over the earth's surface, there are many men and women saying: "I wonder what they are doing at Orpers to-night—dance, darts, billiards or the 'George and Dragon' or the 'Rose and Crown.'" We here, are always thinking of them.

It is our avowed intention at some future date to endeavour to get together a mess dinner in London of Orpington's M.O's, covering the entire period of the War. With Dr. Campbell in the chair, and Professor T. B. Johnston as our principal guest, the rest of us feel that a great evening and an outstanding success would be achieved.

Correspondence

STUDENT HEALTH SERVICE AT GUY'S.

To the Editor of the GAZETTE.

SIR,—I am writing to you because some comments, under "Passim" in the *Gazette* for March 2nd, 1946, might wrongly give the impression that there is no student health service at Guy's.

A student health service was started in 1939, and arrangements were made for the medical and radiological examination of all students entering the Medical School. This scheme was abandoned at the outbreak of war.

In October, 1942, a modified scheme was started. Radiological examinations of the chest were made on all students entering the wards, while Schick and Mantoux tests were done both on first admission to the School and again on beginning clinical work.

The full service was begun again on February 4th, 1946. The present arrangements are as follows:—

1. All students are medically examined during their first year at the School and will be reviewed again during their third and fifth years. Where it is necessary, arrangements are made for individual students to be seen more frequently. It is not proposed to make this part of the scheme retrospective, and these routine examinations will be carried out only on students who entered Guy's during or after October, 1945.
2. All students, irrespective of their date of entry to the School, will have a radiological examination of the chest once a year throughout their undergraduate careers.
3. All students are Schick-tested, and immunisation against diphtheria is carried out in the non-immune. A Mantoux teat is done as well. Other immunological procedures are carried out whenever necessary.

4. Any student who desires medical advice can attend the Out-patient Department on a Saturday morning. He will be seen by one of the medical registrars, who will refer the student to one of the Staff when this should be necessary.

5. Confidential records are kept of these examinations and also of any maladies treated at Guy's or elsewhere.

I am, Sir,

W. N. MANN.

Guy's Hospital, S.E.1.

A PROPOS RECENT ARTICLES AND LETTERS.

To the Editor of the GAZETTE.

SIR,—I think Mr. Cook has misinterpreted the meaning of the "recent articles, ballads and letters published in the *Gazette*" when he suggests that they are based upon a sense of mutual admiration and professional exaltation. The question as to who actually wins battles is an academic one for the study of military experts, and is, I believe, completely outside the point at issue.

The two most important things in the life of the average man on Service are rations and mail, the former to satisfy his creature comforts, the latter to satisfy his continuous craving for news of what is going on at home. Guy's is the parent of a large family scattered far and wide by the recent war. The *Gazette* is one means whereby she can communicate with her children. In these articles, etc., to which Mr. Cook takes exception, the parent is saying to her children: "While you were away they did this to me; while you were away I was not idle." Perhaps one may comment on the style used in her communications, but I am sure that hundreds of Guy's men must be glad to receive "news from home," just as the parent is now only too glad to welcome her returning children and to listen to their story.

I think Mr. Cook has confounded "heroic style" with a claim to "heroics."

I am, Sir,

W. R. SPURRELL.

Guy's Hospital, S.E.1.

MR. W. KING RIST.

To the Editor of the GAZETTE.

SIR,—Old Guy's men, and present Guy's men, visiting Honor Oak Park this season on the afternoon of a Rugby match will have noticed the absence of an old friend to greet them at the gate or in the stand.

I refer to Mr. W. King Rist, who has retired from his position there after forty-two years' faithful and unstinted service to the Clubs' Union and, through it, to the Hospital and School. He took charge of the gate and stand receipts when they were negligible, but, by improving the amenities and by judicious advertising, he gradually built up a large regular attendance so that, at one time, all seats in the stand were booked up at least a week ahead.

This brought in considerable profit for the benefit of all branches of the Clubs' Union, for King Rist's work was a labour of love, the small commission which he received on the receipts being often insufficient to cover his expenses.

I feel that there must be many people who would like to join me in showing their appreciation of King Rist's work for Guy's. I appeal to them to send me a subscription so that we may make him a small presentation as a memento of the many fruitful and happy days he spent with us.

I am, Sir,

W. D. DOHERTY.

10, Upper Wimpole Street, W.1.

TERMINOLOGY IN MEDICINE.

To the Editor of the GAZETTE.

SIR,—I doubt if any medical student disagrees with the plea of Mr. Grummitt and others for the use of a single system of anatomical nomenclature. Personally, I feel strongly about the increased burden of a double system.

Frederick Bodmer, in "The Loom of Language," has said that a medical student must acquire a new vocabulary of ten thousand words, and that to conduct an intelligent conversation in a European language seventeen hundred words are adequate. It is apparent that to learn alternative terms in anatomy and bacteriology, trade names in pharmacology and a double set of weights and measures is to occupy much of our time with no useful result and little interest. To use them in text-books is to obstruct the reader, much as journalistic English obstructs him ; *alors il ne se sert plus de ces livres qu'il lui faut traduire tout le temps.*

Whether the author-surgeons attend to our cry or not, the most important step will be for us, who are students now, to determine that any teaching or writing that we may do in the future shall be phrased in modern terminology. We must forego the delight of mental gymnastics between two systems of terminology ; for there is a certain flavour in the archaic "tibialis anticus" which is lacking in "tibialis anterior, with which any 2nd M.B. student is familiar.

As for eponyms, they serve a purpose in the labelling of diseases which we do not understand. For instance, the "nephritis" found in Bright's disease is not analogous to tonsillitis and it is misleading to term the disease "nephritis."

Other eponymns might be perpetrated in memory of men whose place in the history of medicine should be known to all of us, men who were great.

I am, Sir,

H. W. TRUSTED.

Guy's Hospital, S.E.1.

Sport

Rugby

HOSPITAL CUP COMPETITION.

Second Round.

GUY'S *v.* KING'S COLLEGE HOSPITAL.

(*At Richmond,, Tuesday, February 26th*, 1946.)

Result : Guy's, 31 points ; King's College Hospital, nil.

The glamour of the cup is with us again. Having drawn a bye in the first round Guy's encountered King's in the second and succeeded in winning by 3 goals, 1 dropped goal and 4 tries to nil.

The attendance was very poor, but this was not surprising considering the prevailing arctic conditions—a blinding snowstorm and a strong cross wind ; in the circumstances it was amazing that so much entertaining rugger was packed into the game. Without any doubt Van der Westhuizen was the most conspicuous player on the field, and when he had opened the scoring with a dropped goal against the wind after fifteen minutes' play it was only a question of how many points Guy's would win by ; and it was he who, later, completely baffled the opposing defence to send De Villiers over for a try, which Lewis converted. Thus Guy's had a very useful lead at half-time.

Soon after the interval Macrae-Gibson started a riot of scoring with a grand run for a try in the corner, which was followed by another from Lewis, who dribbled over following a kick ahead by Owen. From a forward dribble Eksteen touched down for Lewis to convert, and then came an accurate movement all along the three-quarter line resulting in Le Clus scoring an unconverted try. Shortly after the same player followed this up with another try when he took a pass from Van der Westhuizen, who had intercepted an opponent's attempt to pass back ; Lewis converted. Hatton had a good dribble, although, unfortunately, his kick went over the dead-ball line, but, to complete the scoring, Dean crossed King's line after some more footwork.

It was only natural that the forwards should have taken control ; this they did with a whirlwind ferocity that completely overwhelmed the King's defenders. The latter, however, stood up to their task valiantly and, indeed, often carried play to the other end but without ever really looking dangerous.

The playing of Van der Westhuizen at stand-off half has undoubtedly removed much of the punch from the three-quarter line and, although the handling of the backs was excellent, considering the conditions there was not sufficient guile in the attack. Nevertheless. it was an excellent all-round performance to commence the series with such a substantial victory. Our sympathies are with King's who, we understand, are having tremendous difficutly in raising a team, and we are sorry to see this once great Rugby-playing hospital in such trying circumstances.

Semi-Final.

GUY.S *v.* MIDDLESEX HOSPITAL.

(*At Richmond, Thursday, March 7th*, 1946.)

Result : Guy's, 7 points ; Middlesex, 6 points.

Guy's earned the right to play in the final of the first Inter-Hospitals contest since 1939 by defeating Middlesex Hospital by a dropped goal and a penalty goal to a penalty goal and a try.

Guy's had great hopes before the match of producing something exceptional, especially as the new back division was considered to possess tremendous attacking power, but our failure to get the ball from the set scrums destroyed all our chances of attacking and when the ball did eventually come out on our side the halves were so slow in getting the backs going that practically every movement was cramped, thus preventing our three-quarters from breaking through.

For most of the game both sides were so deadly accurate with their marking and tackling that three-quarter movements were at a minimum and Guy's can thank their forwards for much of the progress they made towards the Middlesex line. In the loose Hilliam, De Villiers and Hatton were really tremendous and frequently caused the

Middlesex players to go down on the ball in most heroic fashion. If there is any criticism of the forwards it is that they must learn not to get off-side, which they did on many occasions both from the set scrums and the loose.

Our trouble appeared to be at half-back and our lack of success can be contributed to this weakness, but F. Le Clus, in his new position at left centre, shone most conspicuously both in attack and defence and kept a sound check on A. H. Campbell. The defensive play of Macrae-Gibson was one of the features of the match and the manner in which he completely subdued C. D. McIver undoubtedly saved his side on many occasions. So much so that McIver went to left centre later in the game.

After eight minutes' play Lewis kicked a penalty goal for Guy's, but a little later in the first half D. Goss put Middlesex level, also from a penalty. The second half went a little better for Guy's, but apart from one good run by Van der Westhuizen and F. Le Clus, there seemed no hope of crossing the Middlesex line. However, following a rush down the field, the ball came out quickly to D. G. Jones, who calmly dropped a magnificent goal. Guy's supporters were jubilant until the last two minutes, when Middlesex again attacked strongly, and C. D. McIver crossed for a try in a fairly good position, amidst much excitement. There was an anxious silence as the kick was taken but McIver missed, and Guy's won—a victory to which Middlesex contributed by failing with penalty kicks from reasonable positions.

An account of the Final, against St. Mary's Hospital, at the Athletic Ground, Richmond, on Wednesday, March 20th, 1946, will appear in the next issue of the "Gazette."

Hospital Information, etc.

Pass List

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.

February, 1946.

Pass.

E. R. Arnold
A. J. Beale
P. E. Brown
J. C. Crook
H. G. Dixon
T. G. Hooson
R. C. Jennings
W. P. Gurassa
T. Koonvisal
L. V. Martin
J. B. Musgrove
G. F. Penny
C. S. Shaw
B. E. R. Symonds
G. I. Tewfik
J. D. Wallace
P. Westcombe
J. M. Wilks
D. M. Zausner

Supplementary Pass List.

PART I.

P. J. Dwyer
J. K. G. Grieves
J. M. Hall
H. Herbert
J. B. Moore
M. D. Warren
J. T. Woodall

PART III.

G. F. Barnes
A. G. Bearn
K. W. Bolt
D. F. V. Brunsdon
D. W. J. Cullingford
D. J. Dennison
A. E. Doyle
W. E. D. Evans
T. R. L. Finnegan
R. V. H. Goulder
F. L. Jackson
S. L. O. Jackson
C. L. Joiner
T. N. Reynolds
M. D. Warren

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

FINAL EXAMINATION.

February, 1946

PART I.—Surgery.

B. M. Bilton
J. Fenmark
A. A. W. Fooks
R. L. Foster
P. S. Holmes
G. A. Kerr
J. G. L. Knowles
A. K. Parsonage
P. H. Prynne
J. S. Rose
K. Salomon
A. Shotts
J. R. Timms
J. R. Wallis
I. B. Walters

PART II.—Dental Surgery.

S. J. Bell
G. T. Crook
M. E. P. Easton
G. B. Elphicke
J. Fenmark
J. F. A. Flanders
C. M. M. Jenkins
R. T. Lowein
K. G. B. Pritchard
F. M. Scherbel
J. C. Schofield
A. J. Swann
A. E. Trist
P. J. R. Whyte
B. Wotton

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

M.R.C.P.

January, 1946.

H. N. W. Harley
L. Naucekievill

Appointments

A. S. Erulkar, M.D., has been elected President of the Medical Council of India—the equivalent of the General Medical Council.

The Services

AWARDS.

M.C.

In recognition of gallant and distinguished services in the field, Captain A. Crook, R.A.M.C.

Mentioned in Dispatches.

Lieut. S. T. Williamson, R.A.M.C.

Births

HODGSON-TODD.—On February 17th, 1946, at Adlington Hall, to E. R. Hodgson-Todd, wife of M. O. Hodgson-Todd—the gift of a daughter.

PARROTT.—On February 28th, 1946, to Cecily (née Redfern), wife of A. Edwin Parrott—a son.

RANDALL.—On March 10th, 1946, to Helen, wife of Dr. Keith Randall—a daughter (Vanessa Margaret).

ZORAB.—On February 28th, 1946, to Janet, wife of Edward C. Zorab, of 20, Brunswick Place, Southampton—a son.

Marriages

MACDONALD—CUSSEN. — On February 2nd, 1946, at Melior Street Church, S.E.1, Ian Macdonald, M.B., B.S., to Nora ("Norrie") P. Cussen, S.R.N.

Deaths

DAY.—On February 28th, 1946, suddenly, at Mulberry Green, Harlow, Essex, Francis Newcombe Day, M.B. (Camb.).

EDS. { J.M.H. R.H.N.L.

GUY'S HOSPITAL GAZETTE

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PASSIM

EVEN men from this Hospital have been known to bow their heads in mute but eloquent tribute when they recall the enterprise of young William Webb Ellis, who, during a game of football at Rugby School in 1823, picked up the ball and ran with it. Whether it was a fit of absentmindedness or the abandon of pure devilment we shall never know, but Guy's men were quick—indeed, they were among the first—to recognise the potentialities of this apparently innocent manœuvre. There emerged the Rugby Football Club, the centenary of which we celebrated two seasons ago.

Great names and great occasions in Rugby football are legion; to both Guy's has contributed her fair quota. Not least among the latter have been the Hospital Cup finals, in which Guy's has so often played a conspicuous part—both on and off the field. The first final after six precarious years would have been a big event whatever the conditions, whatever the outcome. With the pleasure and privilege of the presence of Their Majesties the King and Queen, before a large and spirited crowd, with the two leading Rugby-playing hospitals as finalists, and on a warm, sunny afternoon the stage was set for that combination of excitement and exhilaration which provides joy for the present and memories for the future. It was gratifying to see so many well-known Guy's men in the grand stand, from whence there came, from time to time, a *blasé* word or two directing the attention of the referee towards various incidents in the game that he might otherwise have overlooked. It is not possible to convey in words the atmosphere of the occasion and not within our province to comment on the play. But we sincerely hope that old Guy's men, with the assistance of the account of the match and the two photographs elsewhere in this number and with the added advantage, perhaps, of memories of former finals, may be able to visualise the scene or recapture the atmosphere. While congratulating St. Mary's Hospital on a victory which seemed to reflect the relative merits of the two sides, we would add a warm word of praise to our own team, who kept the issue in doubt until the last decisive try shortly before the end of the game. The team played true to the excellent form it has shown this season.

No mention of Guy's rugger would be complete without reference to our friends from and in South Africa. Six of them were in the side which represented the Hospital at Richmond, a seventh having the misfortune to contract an illness the day before the match. Their services have always been of a consistently high order and the relationship which we enjoy with the Dominion is a happy and invaluable one. It is very doubtful whether Guy's would have won the Hospital Cup twenty-six times—fifteen times more than any other hospital—without the association of which we have spoken.

Rugby football is the major sport, not only of this hospital but of all the main teaching hospitals, and the ability to play it with brilliance is a passport to eminence. Opinion has for long been divided as to whether, through affording the mastery of an elliptical ball so large a measure of acclamation, the game has thus assumed an exaggerated importance. This is a problem without a solution in so far as national characteristics do, or do not, defy analysis. We would say simply this, that if the spirit and skill which prevailed at Richmond were an indication of the purpose of Rugby football then there can be but little dissatisfaction and few complaints. It is therefore safe to dismiss the critics without comment.

WE would like to congratulate Miss M. Marriott on being appointed Matron of the Middlesex Hospital and to wish her much happiness and success in her new work. Throughout the greater part of the war Miss Marriott was Matron of the War Emergency Hospital, Orpington. We are pleased that another Guy's nurse is to be Matron of the Middlesex Hospital. Miss Marriott succeeds Miss D. M. Smith, O.B.E., who returns to Guy's as Matron in May.

Traumatic Aneurysm & Arteriovenous Fistula

By SOL. M. COHEN, M.A., Cape Town, F.R.C.S.,
Southern Hospital, Dartford, Kent.

A Clinical Lecture delivered at Guy's Hospital on January 10th, 1946.

PART I.—SOME NOTABLE CONTRIBUTIONS BY GUY'S "MEN" TO PERIPHERAL VESSEL SURGERY.

GENTLEMEN,—I am very sensible of the honour and privilege of the invitation to talk to you, and gratefully acknowledge the courtesy of Sir Heneage in giving up his own lecture for me. They tell me that if you really want to learn something about a subject write a book on it. The next best thing is to give a lecture; that certainly makes one winnow one's ideas and fantasies in the breath and, sometimes the froth, of students' opinion. It is a particular privilege to talk on this subject, for we at Guy's have a great tradition of men who have made vast contributions to peripheral vascular injuries. So let us talk for a while of some of the great men of Guy's.

Just over two hundred years ago Joseph Warner of Guy's first had the courage to apply a ligature to the common carotid artery; you will find his writings in the library, and his account of interesting cases shows him to have been an astute observer. There is an amusing story attached to his name concerning a life-long enmity with a St. Thomas's hospital surgeon, Mr. Cowell. Warner had served, together with Cowell, on an expedition of the Duke of Cumberland to suppress the rebellion in Scotland; on their return, Cowell, unbeknown to Warner, applied for and secured a St. Thomas's Hospital surgical vacancy. Warner never forgave this deceit and, whenever entering the Surgeons' Hall, invariably exclaimed: "How do you do, gentlemen? I am glad to see you all, except Mr. Cowell." Warner all but robbed Guy's of one of her greatest sons, for he opposed the appointment of Astley Cooper, of whom you no doubt know. Astley Cooper was the first to tie successfully the common carotid artery for aneurysm, being successful with his second case. I like the way he pays tribute to this patient—a porter at Crawshay's Iron Wharf, Thames Street. "Although he knew that the trial was new, and the risk considerable, he never betrayed the smallest sign of apprehension." We all of us know well the courage and equanimity of the Borough patient; we are, indeed, fortunate to be trained amidst the finest and most lovable patients the world over. Astley Cooper's approach to the external iliac artery is still surgical law; he appreciated the safety of such external iliac ligature and tied it nine times successfully for femoral aneurysm—one case being that of a surgeon who subsequently married and lived happily. Astley Cooper was the first to tie the abdominal aorta in man, after animal experiment. We have here, in front of us, his mounted specimen of a successful ligation of a dog's aorta showing the collateral circulation.

Astley Cooper's case died, but it was a beacon; not until 1925 did Matas (2) have the first successful case. Astley Cooper appreciated, too, the risks of the ligature in continuity—the battering of a fixed stretched point by the pulsating stream. When he describes the ligaturing of the carotid vessel we notice how he divides the vessel between ligatures, in a manner similar to modern practice. Mr. Brock (3) has given us a most stimulating account of Sir Astley's arterial surgery; I commend it to you. He has pointed out that it is not well known that Astley Cooper suggested, and first used successfully, catgut as a ligature. In 1817 "he tied the femoral artery, using a catgut ligature, cut the ends short and closed the wound; it healed by primary intention and the patient was cured." At Astley Cooper's lectures sat John Keats, (4), transcribing the great man's words and we have a record of these notes. Gradually Keats's interest seems to have waned as he turned to his true love—poetry. Professor Ryle (5) has extracted for us from John Keats's notebook a very fine description of an arteriovenous fistula—"the Aneurismal Varix produced by pricking an artery through a vein. The Lancet is pushed through the Median Vein and punctures the Brachial Artery. In a week or ten days the Vein begins to enlarge and pulsates like an Aneurism. If you make pressure above on the Artery and below on the Vein it will disappear. It is fed both by Artery and Vein. There is a constant hissing noise. The Brachial Artery becomes twice its natural size

—the veins are not enlarged . . ." To Guy's Astley Cooper attracted a large number of surgeons from the Continent—Chopart, Baron Larrey, Desaret, Dupuytryen (names familiar to you), these all came. It is recounted how confused Astley Cooper became when Dupuytryen, before departing, affectionately kissed him on both cheeks. Such visits in themselves were stimulating, but he appreciated the dangers of inbreeding and that " busy men are sterile " ; he thus travelled to the Continent and elsewhere to see and to talk of the work of others. His ventures in vascular surgery were numerous, but they were not born from the courage of cool nimble fingers or the impetuous hunch. As a matter of fact he feared much for his patients, and viewed them with charitable eyes. His secret was diligent industry. He once called John Hunter " the most industrious man that ever lived " ; in his heyday he himself must have been a good second. He knew his anatomy well, and two hundred years later Dr. Keith Simpson, (6) at Guy's, was to turn to his account of " The Anatomy of the Thymus Gland," and find in the description of the arrangement of the pretracheal layer of fascia the explanation for the tearing of the great vessels of the neck or upper thoracic region in violent hyperextension of the neck, incidentally, a type of traumatic rupture of major vessels which Dr. Keith Simpson is the first to describe. I must end my short account of this great man by telling you of a little story told of Astley Cooper, whilst attending one of John Hunter's lectures. " Ah, but Mr. Hunter," he interrupted, " you said something entirely different last year ! " " Very likely I did," replied Hunter ; " I hope I grow wiser every year." That is a great lesson of life, and it is the mark of the great man to be able to say : " I don't know " or " I think differently now." Especially in vascular surgery have I been impressed with the fact that what one generation enthrones the other stones.

We now come to John Hilton—" Anatomical John," as he was affectionately called. Although never particularly interested in blood vessel surgery, he has left some sound principles to guide us in our treatment. We have come to realise, particularly in this war, that one of the cardinal principles of his teaching, " Rest for the injured part " has been misunderstood and, to some extent, abused. Quite ten years ago a beloved teacher of Guy's, Mr. C. H. Fagge (7), spoke words on this subject which have passed almost unnoticed ; in paying homage to Hilton he observes : " Physiological rest does not imply immobility . . . it is the acquisition of a state of *eased function* favourable to recuperation and repair " (my underlining). The emphasis on full use of the muscles of the immobilised limb in plaster you know ; early ambulation after the abdominal operation is now being increasingly practised, and it is well to point out that in my student days Mr. " Bobby " Rowlands was constantly preaching it. " I confer on you the freedom of the bed " was his little way of encouraging patients to move immediately after operation. So for the vascular case ; I find that a number of my aneurysm and arteriovenous fistula cases arrive with stiff joints and by ambulance, after long strict bed confinement. I stress to you that the greatest stimulus of all to the development of the collateral circulation is muscular exercise. The patient long confined to bed is " deconditioned," and not in a fit state for the long tedious operation often necessary in these cases. Man is an upright animal ; he will faint after being in bed but for a few days ; he will do the same thing with the change of position as he leaves the operating table. I tell my patients : " An operation is like a game of football—you will feel grand after it, if you have been in training." As there is usually no urgency to operate on these aneurysms we have time to train them.

We pass more quickly to some of the other Guy's men. We recall Mr. Alfred Poland (8), and it is of interest that just over one hundred years ago he won the Jacksonian prize for an essay on gunshot wounds. He was much interested in vascular injuries and in the library you will find articles of his on this subject packed with good advice. His account of subclavian aneurysm is a beautiful example of a detailed fair study of a large number of cases ; and one can well turn to this article for the march of events and the longevity of the conservatively treated case. A neat operator, Poland always chose a quiet hour unknown to nearly everyone in which to perform his operation—not bad advice when it comes to dealing particularly with a difficult arteriovenous fistula Thomas Bryant's (9) name comes before us, and you probably know him better by his triangle for determining the place of the femoral head. His advice on tourniquets still deserves quoting. " The tourniquet . . . although valuable when applied for a temporary purpose, deserves the strongest censure when maintained for any lengthened period. Good ball or firm pad and the arm well raised to a nearly vertical position should be used " Bryant was much interested in the twisting off of

vessels as a method of hæmorrhage arrest ; a technique still often used by some surgeons for the minor vessels. He had such twisted vessels carefully injected and dissected models of them prepared by Joseph Towne, of whose wax models in the museum we are so rightly proud. The torn intima acting as a flap valve and supported by thetwisted external coat is beautifully shown in these illustrated models. We pass on to Mr. Davies-Colley's (10) father, who, in 1888, was the first to teach us in arteriovenous fistula of the enlargement of the proximal artery and the thinning of its wall, of the distal developing large collaterals and the increased temperature of the affected limb. Mr. Davies-Colley, Jun. (11), was to take the same interest in arteriovenous fistula, and fifty-two years later sorted out for us the pathology of what is known as the cirsoid aneurysm.

We approach the present day. Sir Arbuthnot Lane, at the beginning of this century, was to be the first to tie the jugular vein for lateral sinus thrombosis. A recent review recalls, too, that Sir Arbuthnot (12) was the first to recognise the possibility of compression of the subclavian artery and the brachial plexus trunks by the clavicle against the first rib—a subject which has attracted recently much attention. The early years of World War I saw Colonel (later Sir) Charters Symonds (13) open a discussion on traumatic aneurysm at the Medical Society of London ; he pointed to the need for operation on the arteriovenous fistula (which, hitherto, had been generally considered unnecessary). He also put forward the original suggestion that fascia lata or a ength of saphenous vein might be used to half-ligate the vessel proximal to the aneurysm and thus encourage the more rapid development of a collateral circulation. We might here mention that his son, the present Sir Charles, was to take an interest in the congenital intracranial aneurysm, and in 1923 was to draw attention to the clinical symptoms and the possibility of diagnosis at the bedside of such a ruptured aneurysm. The 1914–18 war was in its stride when " Bobby " Rowlands (15) wrote to *The Lancet* urging that the tourniquet be applied during the course of operations for some of the injuries. At that time blood transfusions were hardly ever used ; a pint was the maximum given and the conservation of blood loss was thus particularly important. He pointed out also the principle of clamping or of control of the proximal vessel, which forms such an important step in the modern operation for the dangerously placed aneurysm. Rowlands was the first to advocate and explain the *rationale* of the use of the tight bandage over wool, before removing the tourniquet, as is the common practice in present-day orthopædic surgery. He taught also the principle of elevation, which comes within the management of the anæmic limb. Professor Digby, (16) a Guy's student, wrote, about the same time, advising the use of the pneumatic tourniquet and pointing out the danger of traumatic arterial spasm from solid or tubing rubber. Mr. Nils Eckhoff (17) was later further to emphasise these risks by publishing what has become a classic paper on tourniquet paralysis. That great orthopædic surgeon and character, " Treth " Trethowan, was to teach us much about Volkmann's contracture, and that it may occur with a radial pulse present. The actual contributions from Trethowan's pen were relatively few, but he has left for us a great tradition of orthopædic teaching. Sir Heneage Ogilvie himself has done much vascular surgery ; to his credit stands the only successful case of bilateral popliteal aneurysm resection (18) ; he is one of the few to have operated successfully on an extracranial aneurysm of the vertebral artery (19) ; his evaluation of the role of the sympathetic system in vascular surgery in a paper later in the 'thirties still stands. At the beginning of this War Sir Heneage early appreciated the value of massive rapid transfusion ; more lives have been saved by this than by any other method introduced in this War. Our physicians, too, have made their contribution ; the third case of periarteritis nodosa to be recognised in this country was published by Dr. Hector Cameron and Dr. Laidlaw (20). Professor Ryle (5) has made an important contribution to our knowledge of arteriovenous aneurysm. In a short paper he drew attention well over twenty years ago to " crutch arteritis "—obliteration of the main vessel following repeated trauma by the armpit crutch. It was an important observation, for it helped to point the way that the buffeting of the subclavian artery, as it lies on the first rib by the clavicle, could similarly result in damage to the arterial walls and lead to thrombosis. It led to the dispelling of the original conception that " irritation of the sympathetic fibres in the lowest trunk of the brachial plexus " was responsible for the distal limb signs and symptoms. Dr. Holling, (22) working at Guy's more recently, was able to show on several cases (operated on by Mr. Eckhoff) that in " cervical rib " the clavicle also was the compressing mechanism ; to cure the vascular symptoms of the cervical rib it was thus not enough merely to divide the scalenus anticus (as had been advocated), but excision of the rib itself was necessary. The physiologists have also shown their

interest in vessel injuries ; Mr. Spurrell (23) has made a most interesting experimental study on the question as to whether simultaneous main vein ligature should be practised, if artery ligature has become necessary. He has brought forward good evidence in favour of it—the increase in the patency of the individual channels ; venous ligature diminished the ease of blood escape and led to a more even distribution in the distal circulation. The need for ligature of the main vein has been rather challenged by some workers in this war, but it is to be doubted as to whether they are correct. Mr. Lancelot Bromley (24) has published one of the most successful cases of extensive resection of the external iliac artery followed by end-to-end anastomosis, in a case where the vessel was involved by a seminoma in an undescended testicle. I have already referred to Mr. Brock's vascular writings ; it is well to mention that he was the first to measure directly pulmonary artery pressure in man ; I have found his advice as to the methods of exposure for the innominate artery aneurysm invaluable. (25) The thermocouple, for measuring skin temperature, as commonly used in most hospitals (when available !) was devised by Dr. Grant. (26) You may know of his important work in demonstrating the differing mechanisms in the control of the skin and muscle circulations.

I have spent much time telling you of these things, and then have merely pecked at the work of some in the peripheral vascular field. What a tradition ! Well may we say in the language of the Eastern apologue : "I am not the rose ; but I live with the rose and so have become sweet."

REFERENCES.

(1) Wilks, S., and Bettany, G. T. (1891), *A Biographical History of Guy's Hospital.* London.
(2) Matas, R. (1925), *Ann. Surg.* **81,** 457.
(3) Brock, R. C. (1941), *Guy's Hosp. Rep.* **90,** 201.
(4) Keats, John, *Anatomical and Physiological Note Book* (1934), Oxford.
(5) Ryle, Professor, J. A. (1941), *Guy's Hosp. Rep.*, **90,** 129.
(6) Simpson, K. (1941). *Ibid.*, 196.
(7) Fagge, C. H. (1936), *Guy's Hosp. Rep.*, **86,** 249.
(8) Poland, A. (1860), *Guy's Hosp. Rep.*, **21,** 281.
——— (1869), *Ibid.*, **15,** 47.
(9) Bryant, T. (1869), *Ibid.*, **15,** 285.
(10) Davies-Colley, N. (1888), *Ibid.*, **45,** 347.
(11) Davies-Colley, R. (1941), *Ibid.*, **90,** 134.
(12) Lane, W. (1885). *J. Anat. Physiol.*, **19,** 266.
(13) Symonds, C. J. (1917), *Lancet,* **1,** 483.
(14) Symonds, C. P. (1923), *Guy's Hosp. Rep.*, **73,** 139.
——— (1924), *.Quart. Journ. Med.*, **18,** 102.
(15) Rowlands, R. P. (1916), *Lancet,* **1,** 1013.
(16) Digby, K. H. (1917), *Lancet,* **1,** 164.
(17) Eckhoff, N. L. (1931), *Lancet,* **2,** 343.
(18) Ogilvie, W. H. (1941), *Guy's Hosp. Rep.*, **90,** 180.
(19) ——— (1941), *Ibid.* See Hardy, A. G., and Denham, H. E. H., 244.
(20) Cameron, H. C., and Laidlaw, P. P. (1915), *Guy's Hosp. Rep.*, **69,** 157.
(21) Ryle, J. A. (1922), *Ibid.*, **72,** 434.
(22) Holling, H. E. (1939), *Ibid.*, **89,** 285.
(23) Spurrell, R. S. (1930), *Ibid.*, **80,** 20.
(24) Bromley, L., and Freebody, D. (1941), **90,** 171.
(25) Brock, R. C. (1941), *Ibid.*, **90,** 180.
(26) Grant, R. (1935), *Ibid.*, **85,** 209.

Part II.—Types of Aneurysm; Their Diagnosis and Treatment

THE development of an aneurysm is often a life-saving event for the injured extremity. Blood continues to circulate in the main vessel, and time is given for the repair and enlargement of the collateral circulation; at a later date it will be possible to undertake operation with every prospect of a good result. Two types of aneurysm are to be distinguished—(*a*) arterial (false) aneurysm; (*b*) arteriovenous (arteriovenous fistula).

Arterial (False) Aneurysm.—The term "false" is used, for (as distinct from the "true" aneurysm) no part of the aneurysm sac is derived from the layers of the parent artery; organised blood clot forms the boundary wall. The intimal layer is of new production, and not due to the stretching of the original intima. For an aneurysm to form the entrance and exit wounds must be small; it is the overlapping of the muscular and fascial layers that limits the bleeding and gives the first stage of the "false" aneurysm—the hæmatoma. The large skin wound on the shattered bone will allow blood to escape or pool and the aneurysm does not form. A fluid centre in the midst of the hæmatoma mass does not come to form the aneurysm sac, as is commonly supposed. Makins showed that the hæmatoma forms a solid clot. Within a few hours, sometimes days, a small cup-shaped depression develops, due to the impact of the blood-stream, at the site of attachment of the clot to the vessel wound. The swirling blood enlarges and polishes its inside surface; the cup becomes lined with endothelium growing from the vessel wall; it is now an aneurysm. At this early stage the cup has but frail attachment to the wall of the vessel and the limb needs careful handling. Where the tissues are loose, as in the neck, axilla, or Scarpa's triangle, the hæmatoma mass may be more fluid, with central clot alone plugging the vessel hole. As can be imagined this type of aneurysm is more precarious, and urgent surgery may become necessary. The irregular hæmatoma mass surrounding the aneurysm cup, and infiltrating between the tissue layers of nerves, vessels and muscles, now begins to absorb. In the process there is much cellular reaction, leading to the matting and binding of the tissues, which appear not unlike "firm bacon." Operation, at this stage, is a

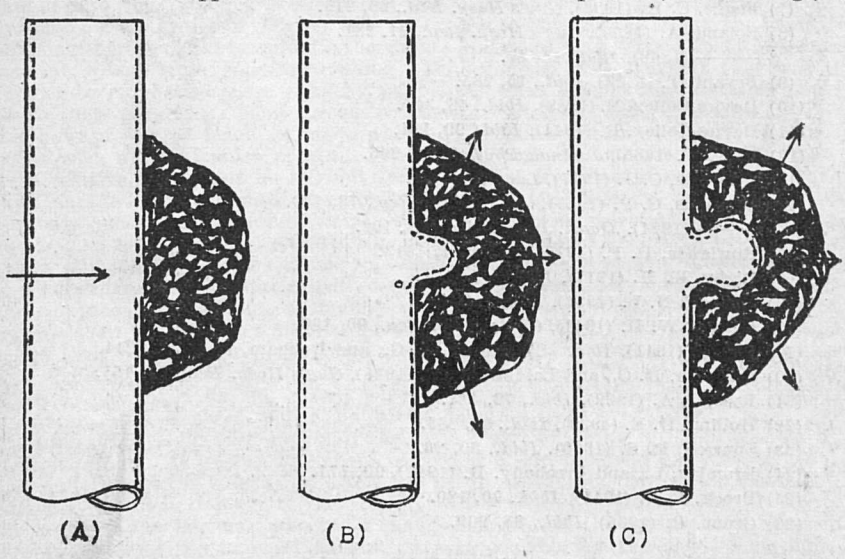

FIG. 1.
DEVELOPMENT OF FALSE ANEURYSM.
(*a*) Hæmatoma stage.
(*b*) Aneurysm cup, lined with endothelium.
(*c*) Enlargement of aneurysm and absorption of blood clot.

formidable affair, for it is difficult to identify the veins and the nerves and the collaterals, as they thread their way through the hæmatoma. With time the sac enlarges, and this is a steady inexorable process, for its walls are fibrous and contain neither elastic nor plain muscle tissue to limit its size (Fig. 1.) The small hole in the vessel stretches, so that when viewed from within the aneurysm sac it appears as if the vessel had been completely divided, and there are separate entrance and exit openings of the parent artery with a shallow gutter between. The pulsating blood against the curved walls of the sac also leads to the rotation of the sac and further distortion of the anatomy of the entering and leaving vessels. (Figs. 2 and 3.)

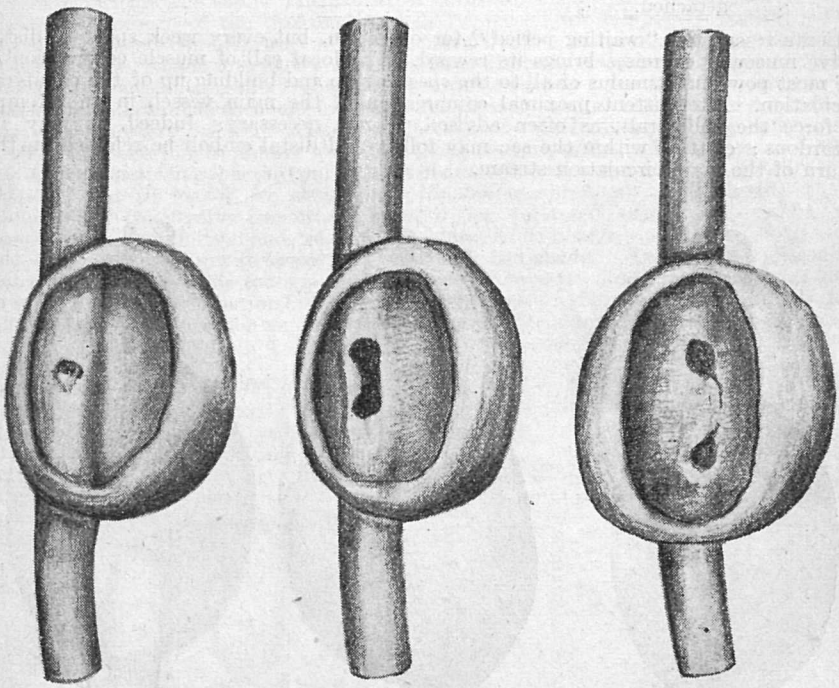

FIG. 2.

ARTERIAL (FALSE) ANEURYSM.

Stretching of hole in vessel wall leads to separate entrance and exit openings in the sac. This gives false impression of a completely divided vessel with intervening aneurysmal wall bridge.

Diagnosis is not difficult. There is a pulsating expansile swelling, controlled by proximal vessel pressure. A systolic murmur, best heard over the entry and exit wounds, is consistently present. The bruit is confined to the aneurysm and not transmitted far on either side of it ; this is an important and helpful aid in differentiating it from the arteriovenous fistula. There is a reduction in the size of the pulse and the blood pressure of the affected limb distal to the aneurysm ; but the nutrition is not affected. There may be pressure effects due to compression of the satellite veins and nerves.

Operation is essential. As we have remarked, the fibrous aneurysm walls will continue to enlarge, and conservative measures will not lead to clotting and cure. But operation should be deferred for three to four months. This serves two purposes—(*a*) the collateral circulation is given time to develop ; (*b*) the softening and resolution of the hæmatoma tissue reaction can proceed, making operation much easier. Operation, however, may be forced by reason of :—

(1) Rapid increase in the size of the hæmatoma or detachment of the early, flimsily attached, aneurysm sac.

(2) Pressure on surrounding structures—veins or nerves—leading to gross œdema or severe pain.

(3) Pressure on the collateral vessels, as indicated by the disappearance of the distal pulse.

(4) Infection. The use of penicillin has made it possible, in some cases, to evacuate the pus by separate incision, leaving the main clot mass attached.

Patients resent the " waiting period " for operation, but every week spent in distal active muscular exercises brings its reward. The local call of muscle contraction is the most powerful stimulus of all to the speeding up and building up of the collateral circulation. Intermittent proximal compression of the main vessel, in an attempt to force the collaterals, as often advised, is not necessary. Indeed, it may be hazardous ; clotting within the sac may follow and distal emboli be released on the return of the main circulation stream.

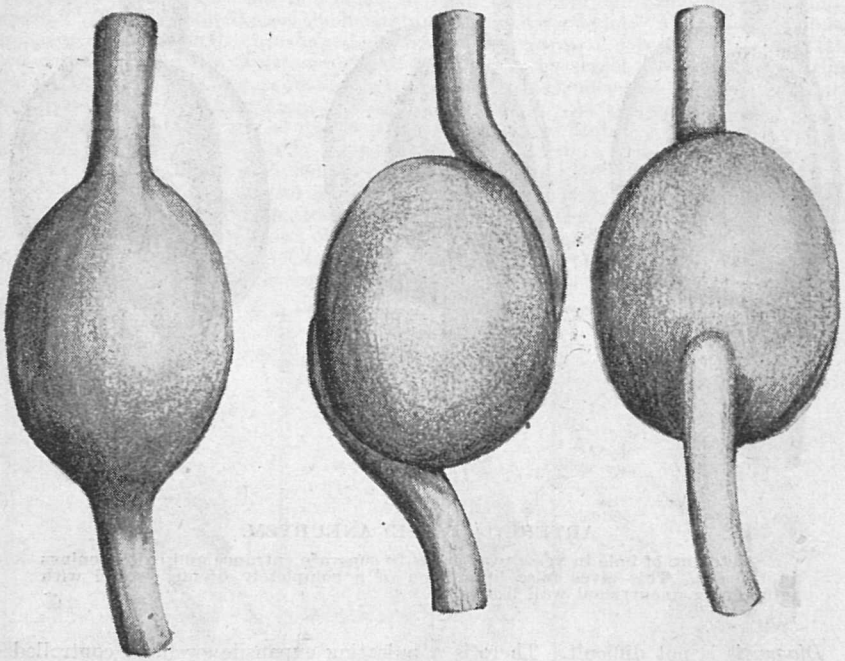

FIG. 3.

ARTERIAL (FALSE) ANEURYSM.

Impact of blood-stream rotates the sac, displacing the entrance and exit openings. (After Matas.)

Operative Measures. When the collateral circulation is adequate, proximal and distal ligature with excision of the sac is the obvious operation of choice. The radial, the ulnar, the external carotid, or collateral vessel branches may be thus safely treated. For the large vessel suture of the vessel opening suggests itself as the ideal. Occasionally this is found possible, for the rotation of the sac leads to stretching of the main vessels on the sac wall, and the two ends may be found to lie closely approximated ; successful end-to-end suture has been recorded in a few cases. It is tempting to trim the aneurysm wall and use it for repair of the arterial gap ; but this should not be done, for the fibrous tissue will stretch and the aneurysm recur. More recently the use of

a vein graft threaded through two vitallium cannulæ (Blakemore and Lord (1)) has been suggested to bridge the arterial gap after aneurysm excision. By this method blood circulates from endothelial-to-endothelial lining and clotting does not take place. The method is still in its infancy and less than half-a-dozen successful aneurysm cases have so far been reported ; experimentally it works well. Its particular application appears to be the case where the surgeon is forced to operate early (before the collateral circulation has had time to develop). The method most commonly used is proximal and distal ligature of the main vessel, as close to the sac as possible ; the sac itself is not necessarily removed. (This is sometimes referred to as the method of Antyllus, who described it in the fourth century A.D., but he also applied an astringent or packing within the sac.) The sac is, of course, opened under tourniquet or after deliberate exposure of the proximal and distal vessels for temporary control. The arterial openings within the sac are now visualised, and a metal dilator, or, preferably, a uterine probe, passed into each ; this facilitates dissection of the entering and leaving vessels, just outside the sac. These are carefully cleared so as to avoid damage to nerves and collateral branches. Ligatures are then applied as close to the sac wall so as to preserve every collateral possible. The ligated vessel trunks are then completely divided ; for the longitudinally stretched fixed ligature point will necrose and give way to the battering of the pulsating stream. The aneurysm sac is usually not removed, and to Matas we owe much for his teaching us, with in the years of memory, this very important point. The collapsed empty sac causes no disability or deformity, and slowly resolves ; to try and remove it is to add the serious risk of injury to important collaterals and nerves. The smooth, glistening endothelial surface of the sac is usually obliterated by a few fine thread stitches ; it is not necessary to refreshen or excise this endothelium, for it has been shown that the surfaces adhere in manner similar to the sutured peritoneal layers. The operation

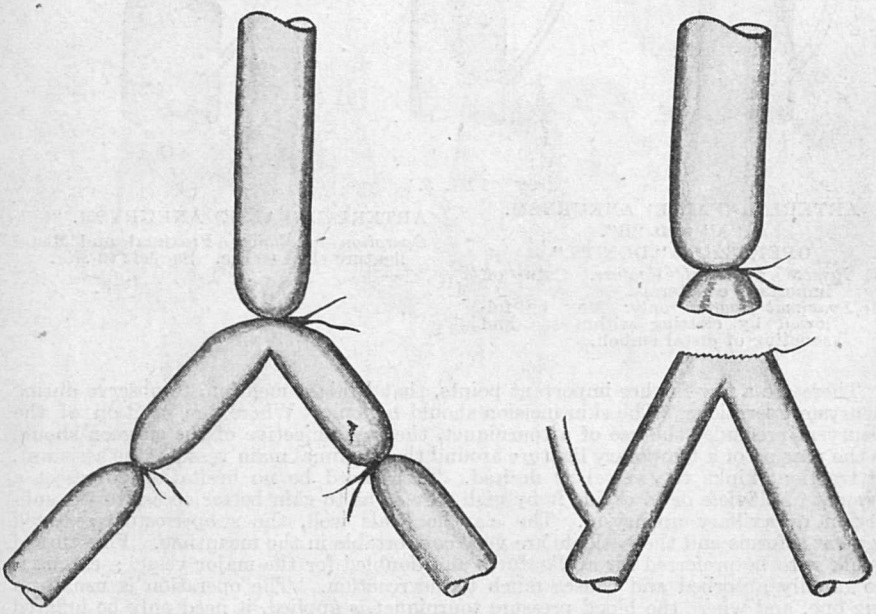

FIG. 4.

(A) (B)

(A) " Triple Ligature "—dangerous.

(B) Suture of short stump. Allows blood flow across vessel crutch.

may have to be modified, especially when dissection outside the sac, however careful, carries the risk of damaging important collaterals ; or where the vessel hole is close to the site of bifurcation of the main vessel. Dissection outside the sac in the latter type of case will necessitate " triple ligature " ; experience shows this to be dangerous,

for on the blood sweeping across the vessel crutch depends the even distribution of the distal flow (Fig. 4). Intrasaccular closure may therefore be advisable. The openings within the sac are closed by one or two figure-of-eight stitches or the vessel mouths may be dissected within the sac and ligatured. The sac is left attached and undisturbed. This valuable procedure is known as Matas' endoaneurysmorrhaphy. It is important to note also that "remote" ligature—*i.e.*, well proximal to the sac, such as the Hunterian ligature in the femoral canal for popliteal aneurysm, has no place in the treatment of the traumatic aneurysm; it will not cure the aneurysm and, besides, will lead to the cutting off of important collateral branches. (Fig. 5.)

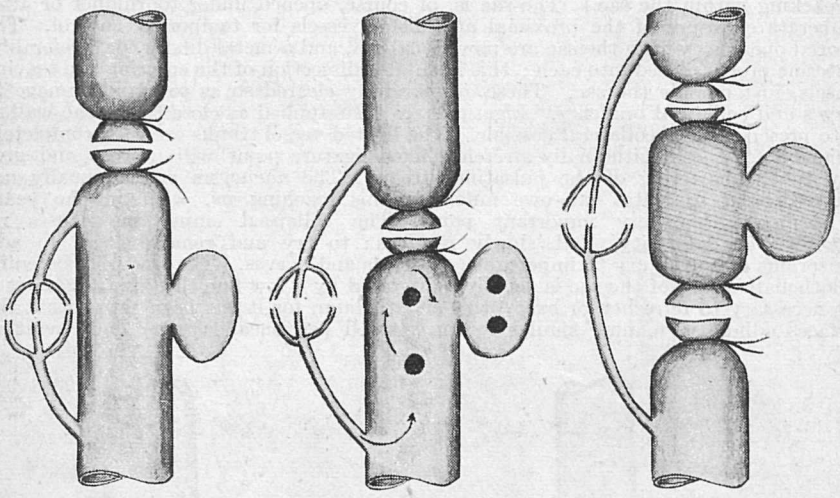

FIG. 5.

ARTERIAL (FALSE) ANEURYSM.
"A" AND "B".
OPERATION "DON'TS."

(A) *Remote proximal ligature.* Cuts off important collaterals.
(B) *Proximal ligature only.* May be followed by clotting within sac and shooting of distal emboli.

ARTERIAL (FALSE) ANEURYSM. "C."

Operation of choice. Proximal and distal ligature close to sac. Sac left *in situ.*

There are a few further important points, that I might mention, to observe during aneurysm operations. The skin incision should be long. Where the position of the aneurysm precludes the use of a tourniquet, the first objective of the surgeon should be the passing of a temporary ligature around the proximal main vessel; the assistant, by traction, kinks the vessel as desired. There need be no hesitation to resect a segment of clavicle or to divide it by gigli wire so as to gain better access to the subclavian or axillary aneurysm. The clavicle heals well, the subperiosteal resected segment reforms and the patients are very comfortable in the meantime. Fine thread or silk is to be preferred for all ligatures and doubled for the major vessel; catgut is too rapidly absorbed and causes much tissue reaction. The operation is usually a long one, and where the blood pressure tourniquet is applied, it need only be inflated at the stage of sac opening. Hæmostasis needs to be complete, and diathermy for the minor points is here invaluable. To drain the wound is to court sepsis, which may be disastrous in this type of case. As foreign bodies often have to be removed during the operation, tetanus anti-toxin should be given. A course of penicillin is always advisable after such extensive secondary operations.

Arteriovenous Fistula.—Two kinds may be distinguished—(*a*) aneurysmal varix; (*b*) varicose aneurysm. Students find the names difficult to remember, and they may be better termed "direct" and "indirect" (there is an aneurysmal sac) communi-

cations. The arteriovenous fistula appears to have been the commoner aneurysm in this war. Both have been often missed, for especially with the aneurysmal varix (with direct opening into the vein) there is but little swelling. The missile causing the lesion is frequently a minute speck fragment and the surgeon has been more concerned with the larger wounds. It is good training to teach oneself to auscultate all such healed scars ; where there is a fresh wound a sterile stethoscope end should be used. (Fig. 6.)

The blood swirling through the fistula into the vein may lead to general severe circulatory disturbances ; the effects of this secondary circuit (which has been well called a " parasitic circulation ") will depend on the size of the opening and the vessel involved. It is to be remembered that the artery on the proximal side of the fistula is usually much dilated, and with a vessel of size one-fifth to one-half of the left ventricle's output may pass through the fistula. The effects of the leak are similar

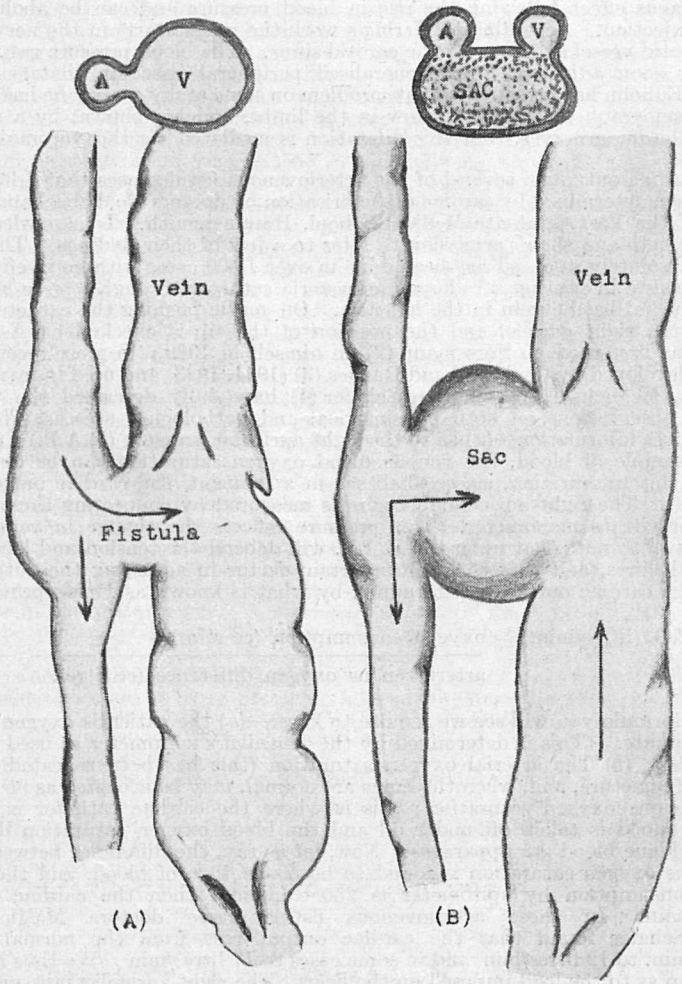

FIG. 6.

ARTERIOVENOUS FISTULA.

(A) *Aneurysmal Varix.* Direct communication.

(B) *Varicose Aneurysm.* Indirect communication *via* sac.

to that of aortic regurgitation, the only difference being that in the latter blood leaks back into the ventricle. Characteristically, therefore, there is a large pulse with low diastolic pressure; for the fistula short-circuits the high resistance of the small bore arterioles and capilliaries in the distal limb. The systolic pressure falls at first, for it must be remembered that the maintenance of blood pressure level depends on the cardiac output and the peripheral resistance (blood pressure = C.O. × P.R.). The increased amount of blood returning to the heart, however, increases the cardiac output and the systolic pressure rises to its normal limits (the low diastolic remains). To cope with the increased volume of blood the heart accelerates—and, later, hypertrophies and dilates. Closure of the fistula by proximal arterial compression will be round to slow the heart, and the systolic and diastolic, pressures rise. This flowing of the heart is known as "Branham's bradycardia." (Branham was an American physician and described this sign some seventy years ago; it was independently recognised by Lewis just after the last war.) This slowing of the heart is a reflex vagus effect following the rise in blood pressure and can be abolished with atropine injection. According to Hering's work the reflex starts in the nerve endings on the carotid vessel and acts *via* the carotid sinus. The blood pressure rise, on fistula closure, is soon adjusted, for a generalised peripheral vascular dilatation follows. Professor Edholm has investigated this problem on some of my cases; he has confirmed by plethysmograph the increased flow in the limbs, and has shown, by a method of blocking the main nerves, that this dilatation is mediated *via* the vasomotor nerves.

The cardiac output in several of the arteriovenous fistula cases that I have shown you has been determined by cardiac catheterisation by doctors McMichael and Sharpey-Schafer of the Post Graduate Medical School, Hammersmith. I acknowledge gratefully their help and their permission to refer to a few of their findings. The method, which is absolutely safe and has been done in over 1,500 cases with no ill-effects whatsoever, consists in passing a radiopaque ureteric catheter through a wide-bore needle into the medial basilic vein in the left arm. On gentle pushing the catheter finds its way into the right auricle, and the position of the tip is checked by X-ray. The method was first used by Forssmann (2) on himself in 1929; in more recent years it has been developed by Cournand and Ranges (3) (1941, 1943) and used in investigations on shock. McMichael and Sharpey-Schafer (4) have fully described the technique, and their observations on both physiological and pathological states. This cardiac catheter gives information—(*a*) as to the right auricular pressure (R.A.P.); (*b*) and by taking a sample of blood, the venous blood oxygen saturation can be determined; and from this information, as we shall see in a moment, the cardiac output can be worked out. The right auricular pressure is measured by connecting the catheter to a saline or citrate manometer. This pressure reflects the change in venous filling, and it is well to note that upon the R.A.P. will depend the tension and length of the myocardial fibres, and it is thus an important factor in adjusting the output of the heart. The cardiac output is determined by what is known as Fick's principle:—

$$\text{C.O. (litres/min.)} = \frac{\text{oxygen consumption (cc min.)}}{\text{arteriovenous oxygen difference (cc litre).}}$$

From the formula you will see we require to know—(*a*) the patient's oxygen consumption per minute. (This is determined by the Benedict's spirometer as used in B.M.R. estimations.) (*b*) The arterial oxygen saturation (this has been repeatedly checked by arterial puncture, and, when the lungs are normal, may be accepted as 95 per cent.; (*c*) the venous oxygen saturation; this is where the cardiac catheter is used) a sample of blood is taken off under oil and the blood oxygen saturation determined by the Haldane blood gas apparatus. Now, let us say, the difference between arterial and venous oxygen saturation is found to be 50 c.c./litre of blood, and the patient's oxygen consumption by spirometer is 250 c.c./min.; then the cardiac output is 5 litres/min. In these arteriovenous fistula cases doctors McMichael and Sharpey Schafer found that the cardiac output rose from the normal figure of 5.5 litres/min. to 12 litres/min and in some cases to 17 litres/min We thus have exact information as to the load imposed on the heart The right auricular pressure (R.A.P.) instead of being about minus 4 C.M. saline was plus 3 C.M. saline. On closure of the fistula shunt by proximal pressure, the cardiac output fell from 12 to 8 and the R.A.P. fell from plus 3 to plus 1. We note, therefore, that there is not a return to the normal figures and operation will not immediately and completely relieve the heart. (Incidentally, in the above case, from which these figures are selected, on closure of

the fistula the pulse-rate fell from 80 to 60, and the diastolic pressure rose from 55–75 mms. Hg.) On giving atropine to block the vagus, the pulse-rate rose. It was now found that the cardiac output was as much as 23 litres/min.; on closure of the shunt the cardiac output fell to 17 litres/min. We gather several important surgical lessons from these studies, and these are Dr. McMichael's observations :—

(*a*) The immediate effect of operation is not a relief on the heart.

(*b*) Pre-operative atropine is not advisable, for it will merely embarrass and increase the heart load.

(*c*) The arteriovenous fistula case does not need pre-operative transfusion; but, in fact, should lose a pint of blood at operation.

Local Condition.—The local shunt deprives the distal limb of some of its blood. As Lewis (5) well put it : " This territory is in a state of active hyperæmia, due to the accumulation of vasodilator substances." This, strange as it may sound, is a magnificent fertiliser of vessel growth and leads to the development of an abundant collateral circulation ; there may even be a greater flow than that to the normal limb. The distal collateral arterial branches become tortuous and often papable owing to the increased growth, both in diameter and length. The artery proximal to the fistula dilates and this dilatation may extend occasionally as far back as the heart. The vein receiving the arterial blood is much dilated and thickened. It is an interesting example of Wolff's law ; increased function leading to hypertrophy and hyperplasia. Nature makes the vein into an artery to meet the increased pressure. The vein valves, however, usually hold, and no gross distal venous distension or varicose veins are usually to be found. Some limb œdema is, however, often present in the case of the lower limb. The exact placing of the site of the fistula in the vessel involved, would naturally be a great help at operation. The thrill and the bruit—at the site of maximum intensity—serve as a guide, but not accurately so. Arteriography, using " pyelosil," is sometimes useful. I have found that by injecting the vein low down and obstructing the proximal flow of artery and vein by tourniquet or pressure, the fistula can sometimes be demonstrated. The medium fills the vein, and as it spills through the fistula into the artery, the anatomy may be clearly seen. As the vein is large in these cases, a considerable quantity of medium may have to be used.

Diagnosis.—This is easy provided the condition be borne in mind. There is a continuous vibratory thrill, not unlike the feel of the purring cat, or at times like bubbling water. The thrill is due to the differences in pressure between the vessels ; the swirling blood starting the vein walls vibrating. The loud, noisy, rough murmur is characteristic ; an important point being that it is " continuous " and with loud systolic intensification ; it is transmitted for a considerable distance up and down the course of the main vessel. " Machinery murmur " is the usual description, and the systolic puff may be heard breaking through the background of the continuous busy factory rumble. Perhaps the best description is that of the noise within an enclosed station yard as a puffing train pulls out. Both bruit and thrill are obliterated by light proximal pressure or blood pressure tourniquet sufficient to arrest the venous flow.

Operation.—This should be delayed four to six months to allow of full development of the collateral circulation. The mental condition of the patient (harassed in some cases by the noise of the bruit) or the cardiac state, may force an earlier operation. There is such an abundant collateral circulation in these cases that it is generally agreed that quadruple ligature and excision of the fistula is undoubted the operation of choice. Time and again at the end of the operation, despite the excision of a large segment of artery, one finds the distal pulse fully present. It is tempting to open the vein, seek the arterial opening, and close it by suture ; but the vein and artery are often closely bound together, and such vessel repair is not easy ; it may be followed by secondary hæmorrhage or recurrence. As Paterson Ross (6) has pointed out recently, to leave the full main artery and to ligature the vein, as this operation implies, leads to unpleasant effects, particularly in the leg on walking. Vein grafts have been used to replace the arterial gap after quadruple excision, but they are unnecessary and merely constitute a triumph of technique. I want to warn you also of two alternative operations which should *not* be done :—(1) " Distal ligature " (this will shunt even more blood through the fistula) ; (2) " proximal ligature " (this should under no circumstances be practised. The collateral flow in the distal channels finds

an easier escape *via* the fistula and, as Makins (7) puts it, "the distal limb bleeds to death." I want to stress again that alternative operations to the quadruple ligature are rarely called for. There is some difference of opinion amongst surgeons as to whether sympathectomy should be done, some two or three weeks prior to operation. My own experience is that it is not necessary, and the extensive experience of Elkin (8) in this war is a comforting support. He has treated some 106 false aneurysms in which some form of major vessel interruption became necessary. In no case did he perform a sympathectomy; none developed gangrene or other untoward ill-effects of the distal limb. (Fig. 7.)

Lastly, I want to stress to you just a few points in the post-operative management of these cases. The aneurysm case should be kept on the warm side, for this leads to reflex vasodilatation in the peripheral vessels. It achieves as much as the sympathectomy. Where the patient has lost blood this should be replaced; if the loss has

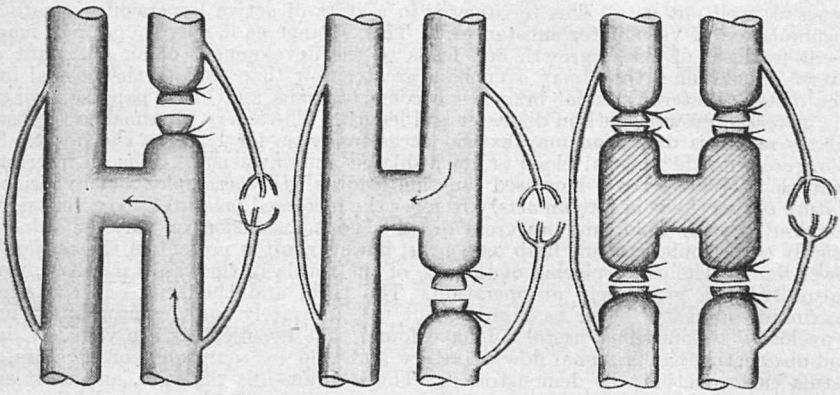

FIG. 7.

A — ARTERIOVENOUS FISTULA. "A" AND "B". OPERATION "DON'TS."

(A) *Proximal ligature only.* Easier escape of collateral flow into fistula. "Limb bleeds to death."

(B) *Distal ligature only.* More blood diverted through fistula.

B

C — ARTERIOVENOUS FISTULA. "C". QUADRUPLE LIGATURE AND EXCISION.

Operation of choice. Hatched area excised.

been at all marked Nature rations the blood supply, and marked peripheral vasoconstriction may be maintained. The patient must sleep, for it has been shown that if thermocouple leads be connected to the toes, maximum vasodilatation readings are observed during sleep. Morphia is indicated and regular doses of luminal. But the morphia should not be given in too large doses; the maximum analgesic effect is obtained with one-sixth of a grain (Hardy, Wolff and Goodell, (9) 1940). It is a disadvantage to depress the respiratory centre, for the suction effect on the venous and lymph circulations is a valuable aid to the arterial inflow; indeed, regular deep breathing exercises should be encouraged. The patient should be nursed on the unaffected side—especially with a femoral vessel injury; the gluteal collateral flow is particularly important. Splinting of the operated limb is usually best avoided; some of these patients have contractures due to previous poor supervision. Violent bandaging to a splint, under the anæsthetic, often leads to stretching and obliteration of the collateral vessels around the joint. The limb should be kept moderately elevated, not above heart level. "The customer is right" is a sound rule; if the patient complains of pins and needles or pain, the limb should be lowered. The dangers of warming the ischæmic limb are now well appreciated; the local metabolism is increased, and the consequent high oxygen demands cannot be met. The limb should be kept lightly exposed under the cradle. It should not, however, be iced or excessively cooled. This leads to peripheral vasoconstriction, interferes with metabolite forma-

tion, and hæmoglobin does not dissociate and part with its oxygen below 50° F. (10° C.). Active muscle exercises should be started early. Finally, these cases, like the acute abdomen, need careful post-operative watching. Here is a story with obvious moral It is told of the Russian surgeon Oppel, who in 1913 first advocated the need for ligaturing the main vein in cases of senile gangrene—an operation whose popularity has recently returned. The story goes that Oppel operated three times in one day on an arteriovenous aneurysm of the axillary artery. He first of all tied the artery; it was noticed that the hand remained cold and white. Back to the theatre went the patient and the main vein was tied. There was no improvement and, after a period of waiting, back to the theatre went the patient for the third time. Oppel now tied the artery below the sac and removed the sac with its connecting veins. Immediately the hand became warm and red, and the man ultimately completely recovered his health. "*Nec temere, nec timide*" (neither rashly, nor timidly) might well be the guiding philosophy of the surgeon as he approaches the aneurysm.

REFERENCES.

(1) Blakemore, A. H., and Lord, J.W. (1943), *Ann. Surg.*, **117**, 481.
——— ——— (1945), *J. Amer. Med. Ass.*, **127**, 685, 748.
(2) Forssman, W. (1929), *Klin. Wschr.*, **8**, 2085.
(3) Cournand, A., and Ranges, H. A. (1941), *Proc. Soc. exp. Biol. N.Y.*, **46**, 462.
Couranud, A., Riley, R. L. *et al.* (1943), *Surgery*, **13**. 964.
(4) McMichael, J., and Sharpey-Schafer, E. P. (1944), *Brit. Heart J.*, **6**, 33.
(5) Lewis, T. (1940), *Clin. Sci.*, **3**, 276.
——— (1934), "*Clinical Science*," Shaw & Sons, England.
(6) Ross, J. P. (1946), *Brit. Med. J.*, **1**, 1.
(7) Makins, G. H. (1919), "*Gunshot Wounds in the Blood Vessels*," Bristol.
(8) Elikin, D. C. (1946), *Surg. Gynec. Obstet.*, **82**, 1.
(9) Hardy, J. D., Wolff, H. G., and Goodell, H. (1940), *Am. J. Physiol.*, **129**, 375.

Correspondence

A SYRINGE SERVICE AT GUY'S.

To the Editor of the GAZETTE.

SIR,—Recent study of the Medical Research Council's War Memorandum No. 15, dealing with the sterilisation, use and care of syringes, has led us to reflect on the condition of instruments available for routine investigations in the wards at Guy's. In section 2 of the report it is stated that any syringe employed for aspiration, whether of blood from a vein or pus from an abscess, should be cleaned and sterilised before it is used again.

Reference to the section of the report dealing with the disinfection of syringes by means of alcohol, which is the material supplied in the wards at Guy's, leaves us in no doubt that this method is far from reliable when working with the glass-metal type of syringe. Seventy per cent. alcohol appears to destroy vegetative organisms in all-glass syringes, but "glass-metal syringes cannot be disinfected with certainty by this method." The report then states: "Syringes used for aspiration and for venepuncture, and all syringes used in hospitals and clinics should be sterilised by heat."

The distribution of heat-sterilised syringes to the wards by a syringe service, as suggested in the Memorandum, seems a reasonable and desirable solution to the problem, despite the initial expense incurred by purchasing all-glass instruments.

We are, Sir,

K. F. ANDERSON,

A. S. BLIGH.

Guy's Hospital, S.E.1.

Sport

Rugby

HOSPITAL CUP COMPETITION.

THE FINAL.

GUY'S *v.* ST. MARY'S.

(*At the Athletic Ground, Richmond, Wednesday, March 20th*, 1946.)

Result: Guy's, 8 points; St. Mary's, 18 points.

Before the game began there was the usual ragging which by no means reached pre-war hilarity, and the milk-churn was never in any danger of being captured. St. Mary's turned up with a baby elephant.

Their Majesties arrived promptly at three o'clock and, following their introduction to Mr. Emile De Lissa (Secretary of the Richmond Club), Colonel Jock Hartley (of the Rugby Union), Mr. L. R. Broster (President of the United Hospitals), Mr. Harry Millett (United Hospitals' Honorary Secretary), Mr. W. D. Doherty (President of Guy's R.F.C.), and Dr. Dickson Wright (President of St. Mary's R.F.C.), the King shook hands with the players.

Let it be recorded that Guy's more than upheld the great traditions of the club and, although St. Mary's won by 3 goals and a try to a goal and a penalty goal, there were periods throughout the game when it seemed possible for Guy's to win. A last-minute change was necessary in the Guy's team owing to the illness of A. De Villiers, but we were fortunate in having P. S. Carton-Kelly, an Oxford war-time blue, to come in as deputy.

It is hoped that Ivor Hilliam, the captain, will not be unduly depressed over the result.

MEMBERS OF THE TEAM *Fox Photos Ltd.*
BEING PRESENTED TO HIS MAJESTY THE KING

He has worked extremely hard since he took over the captaincy at the end of last season, to build up a team for this great day. He has been faced with many disappointments, especially regarding injuries and in finding the best back formation. The final selection was made with every degree of care, and it is doubtful whether any other combination would have done better. It must also be noted that soon after the start F. Le Clus, at left centre, tore a thigh muscle, an injury which severely handicapped the three-quarter play.

Guy's forwards were magnificent and frequently came close to scoring. In the first *half they 'shoved' their full weight and in doing* so provided Harrett with numerous chances to get the backs moving. The possible result of one particularly fine cut through by Van der Westhuizen, which carried him well into the St. Mary's "25," was ruined when R. W. Watson intercepted a pass from F. Le Clus to his brother on the left wing. It was quite obvious that F. Le Clus was feeling the effects of his injury. So evenly matched were the teams that scoring chances were limited; close marking and keen defensive play were features of the game which, although interesting to watch, was not productive of open three-quarter movements, and it was a fair reflection on the play when the sides changed over with no score.

The second half opened with St. Mary's well on their toes, and Hall once cut through only for Scott to knock on. Eksteen was prominent in dribbling and tackling, but the St. Mary's triangle of Hall, Bennett and Scott was constantly trying to find openings. Eventually O'Connor followed up a kick, which *ran awkwardly for our defenders, and succeeded* in touching down for an unconverted try.

Following some good tackling by Hilliam and two short kicks to touch by Harrett, Guy's were awarded a penalty just inside the St. Mary's half, but Lewis's kick fell a yard or so in front of the posts. St. Mary's then renewed the attack with a break through by Devine, who sent Scott through to give the

"THE MILK CHURN" *Fox Photos Ltd.*

final pass to Bennett for a try, which Scott converted. Thereupon Van der Westhuizen went to stand-off half, but Bennett made a delightful run during which he evaded three Guy's men for a try near the posts and again Scott converted.

Guy's made a grand rally and were awarded a penalty from which Lewis easily scored and they further reduced the lead when Hatton beat Bennett for the touch down following a kick ahead by Eksteen; Lewis added the extra points. With only four minutes to go it still looked as if Guy's might save the game, but Hall, receiving the ball from a scrum, cut inside to outstrip the Guy's defence, unmolested, for another try, which Scott converted in the very last minute of an exciting game.

It is a tribute to the players that they played hard all through and never gave up, but St. Mary's proved themselves the better team, holding an advantage outside the scrum which Guy's found just too much for them. Our own three-quarter movements were affected by the injury sustained by F. Le Clus and the backs were quite unable to feed the wings. The forwards appeared anxious to break more quickly from the scrums in the second half and no doubt this deprived us of as much of the ball as we had enjoyed in the first half. There were flashes of individual brilliance in the Guy's team but, rather than particularise, let us congratulate the team as a whole for their fine effort, and especially Hilliam for his excellent captaincy and sound leadership.

Team.—T. L. T. Lewis; N. K. Macrae-Gibson, F. Van der Westhuizen, F. Le Clus, D. Le Clus; P. J. Dwyer, P. D. V. Harrett; R. A. Dean, J. Keeling, C. H. Kinder, A. G. MacCallum, I. H. Hilliam, B. Eksteen, M. Hatton, P. S. Carton-Kelly.

Hospital Information, etc.

Notices

TESTIMONIAL TO
MISS E. E. P. MACMANUS.

On the occasion of her approaching retirement from the post of Matron of Guy's, Miss E. E. P. MacManus will be made the recipient of a testimonial by the Governors and Staff of the Hospital in recognition of the outstanding services which she has rendered during her period in office. Many old Guy's men will, no doubt, wish to signify their appreciation of Miss MacManus' services by subscribing to the Testimonial Fund. Subscriptions should be addressed to the Clerk to the Governors, Counting House, Guy's Hospital, and cheques should be made payable to Guy's Hospital Testimonial Fund. All subscriptions will be acknowledged with an official receipt of the Hospital.

The arrangements for the official presentation of the testimonial will be announced later.

FINAL M.B., B.S. EXAMINATION.

Candidates who passed the Second Examination for Medical Degrees in or after March, 1945, are required to have attended a clinical course extending over not less than 30 months before entry for Part I and not less than 36 months before entry for Part II of the M.B., B.S. Examination.

The additional M.B., B.S. Examination which has been held in January or February during the last four years has been discontinued—*i.e.*, it will not be held in 1947 or thereafter.

GUY'S HOSPITAL DENTAL SCHOOL.

North-Western University Dental School, Chicago, U.S.A., Scholarship.

A Scholarship is offered to a graduate of Guy's Hospital Dental School, on the nomination of the Dental Council, at the North-Western University Dental School, Chicago, as from September 1st, 1946. Details of the Scholarship may be obtained from the Medical School Office.

DENTAL TRAVELLING SCHOLARSHIP.

A Scholarship, confined to registered licentiates of the Royal College of Surgeons of England or holders of a Dental Degree of a British University, who have been educated at Guy's Hospital Dental School, enabling the holder to pursue a course of at least six months' practical work in dental surgery at one or more Colonial or Foreign Dental Schools, will be awarded in April, 1946. The value of the Scholarship is £250, and the Scholar will be required to proceed abroad at such time as will enable him to commence the course in October, 1946. Further details may be obtained from the Medical School Office.

Applications for nominations for both the above Scholarships should be lodged with the Dean, in the Medical School Office, on or before April 13th, 1946.

NINETIES CLUB (GUY'S HOSPITAL).

Union of "Goblins" and "Contemporaries."

The annual dinner of the above club will take place at the Trocadero Restaurant, W.1, on Wednesday, May 22nd, 1946, at 7.30 p.m., with Mr. Philip Turner, M.S., in the chair, preceded by a meeting at 7 p.m.

Price of dinner £1 1s., exclusive of wine. Will any who entered Guy's in the 'nineties, who do not receive through the post a notice of this dinner, and who would like to attend, please send their names and addresses to the undersigned. E. B. DOWSETT.

12, Gloucester Place,
Portman Square, W.1.

Pass List

CONJOINT BOARD.
PRE-MEDICAL EXAMINATION.
March, 1946.

Chemistry.

W. F. Dobson	G. F. Thompson
P. R. Jones	R. V. Warren
A. P. Leech	F. J. H. Van der Westhuizen
W. D. V. Ryan	
H. G. S. Thomson	J. L. Wynne

Physics.

M. F. Ashby	A. B. Price
D. W. Campbell	W. J. A. Reed
H. E. H. Gillett	W. D. V. Ryan
M. J. Humphry	P. J. Saville
A. E. Jacques	G. F. Thompson
P. R. Jones	

Elementary Biology.

A. N. Du Plessis	D. H. M. C. Romans
P. R. Jones	G. F. Thompson
A. B. Price	J. L. Wynne

Marriages

BROOKS—COUCH.—On March 14th, 1946, at St. Michael's Church, Newquay, by the Rt. Rev. Bishop Holden, D.D. Reginald Brooks, of Lagos, Nigeria, to Lucy Couch, S.R.N.

EDS. { J.M.H. / R.H.N.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LX No. 1506 *13th April 1946* *Ninepence*

PASSIM

THE White Paper on the Government's new National Health Scheme covers a subject which occupies a prominent position in all our thoughts to-day. It is the scaffolding around which is to be built an organisation that will directly or indirectly colour the future of every one of us.

It is for this reason that we are pleased to include in " Passim " this fortnight an article written by Professor Johnston dealing with this most important subject inasmuch as it affects the Hospital.

GUY'S AND THE NATIONAL HEALTH SERVICE BILL

By T. B. JOHNSTON, C.B.E., M.D.

(*Superintendent of the Hospital*)

THE National Health Service Bill recently laid before the House of Commons gives a good indication of the intentions of the Government, but until the Bill appears in its final amended form after the Third Reading it will not be possible to obtain a clear picture of the ways in which Guy's will be affected by it. We can, however, at once express our relief on learning that the threat of local authority control, which was such a prominent and unpopular feature of the earlier White Paper, appears to have been removed. Instead, Guy's, like all the Teaching Hospitals, is to retain a large measure of autonomy, and will take part in framing the general plan for the Hospital services in its area.

England and Wales are to be divided into some twenty regions, with each of which there will be associated a University and one or more of its Teaching Hospitals. It is understood that several regions will extend into the centre of London, and, therefore, that the London area will not form a single region. Each region will have its own Regional Hospital Board, and it is hoped that this body which, with the co-operation of the Teaching Hospital or Hospitals concerned, will be responsible for planning a co-ordinated hospital and specialist service for its area, will prove to be a body of experts, not susceptible to political influence. Indeed, in view of its functions, it is most important that it should not be the plaything of party politics. The Regional Boards, however, will not exercise control over the Teaching Hospitals, for these are to have specially appointed and independent Boards of Governors.

Our chief interest lies in the way in which Guy's, as we know it, will fit into the new service, how the Hospital is to be modified to adapt itself to it, what it stands to gain and what to lose.

In the first place there is to be a change in the character of our Governing Body. Hitherto we have been governed by a Court of sixty Governors, vacancies on the Court being filled by invitation. This has been almost entirely, but not exclusively, a lay body, and has comprised men of distinction in many different spheres. Appointed for life, many, though never losing interest in Guy's, have naturally tended to become less active with advancing years, but there have always been some fifteen to twenty-five who have been actively interested in one or more of the various aspects of the Hospital's work. As a result, when decisions have to be taken, the Court invariably finds itself with expert advice available. But the Court, as it has existed for the past 220 years, is to be abolished and its place will be taken by a new Board of Governors, its size still undecided, comprising representatives of the University, the Regional Hospital Board, the Medical and Dental Staff of the Hospital, the London County Council, the Borough Councils of Southwark and Bermondsey and the existing Governing Body. There is a very real danger lest the commendable desire to give representation to so many interested parties should result in the setting up of a Governing Body which is unfamiliar with the Hospital, its past history, its present problems and its plans and hopes for the future. It is imperative that the size of this new Board, on which the fortunes of Guy's will depend, should be such as to ensure the retention of a sufficient number of the present Court to preserve continuity.

In the second place, the financial position of the Hospital is to be assured by " block grants or otherwise," and the Minister has recently stated publicly that there will be no need for the Board of Governors to use the Hospital's endowments for ordinary maintenance. In the period between the two wars the Hospital finances were a constant source of anxiety to the Governors, who frequently found themselves unable to undertake expenditure, even though they were convinced of its desirability. Nevertheless, in those twenty-one years, Guy's, though going short in some respects, went ahead in others, thanks to the generosity of many benefactors, chief of whom was our President, Viscount Nuffield. The Physiotherapy Department, the Out-patient Department, Nuffield House, the Children's Ward, Victoria Ward, the Nuffield Nurses' Home and the York Clinic were all provided in those lean years and represent a total outlay of approximately £400,000. There is some real satisfaction to be obtained from the knowledge that at the present time the Hospital not only is not in debt, but, in fact, has a substantial nest-egg put aside against the cost of the new Guy's.

Under the new Bill the Board of Governors will be able to utilise existing endowments for fresh developments. Before the War these endowments brought in an annual income of about £65,000, but almost invariably the whole of this was required to meet the steadily rising costs of maintenance. Unfortunately, enemy action has reduced this total to the neighbourhood of £50,000 for the time being, but the new Board will have the wherewithal to foster progressive undertakings and to encourage new ideas. No doubt, too, many belated improvements will be effected, and we can look forward to a comprehensive " follow up " department, an adequately staffed and well organised " Back Surgery," a Recovery Hospital in the country (for which, incidentally, the preliminaries were completed some time ago), an adequately staffed Fracture Department, etc., etc.

As set out in the Bill all the Hospital premises " will be transferred to and vest in the Minister." Just what this will imply is entirely obscure, for it is, naturally enough, to be a duty of the Board of Governors to maintain the premises together with their furniture and equipment. It may be that this particular clause, as applied to Teaching Hospitals, means nothing, but it could quite easily lead to difficulties and complications, and one would feel happier if, having made the gesture, the Minister agreed to restore the buildings to the Board of Governors.

It is implied in the Bill that by paying his National Insurance contribution the man-in-the-street becomes entitled to Hospital treatment and the advice of a consultant when necessary. The payments which the Hospital will receive from the State will cover the cost of treatment as well as the cost of maintenance. That is to say, the Hospital will be in a position to pay the Visiting Staff and will be required to do so. This is not entirely a new departure at Guy's, for some members of the Staff have always been in receipt of a small annual payment, but it is to be presumed that the payments to be made in future will bear some relation to the value of the services rendered. There will no doubt be many who will view with some misgivings the disappearance of the " Honorary " Staff, but the change is overdue and it would, in any event, have been precipitated by the altered economic conditions in the country.

In future vacancies on the Visiting Staff will be advertised, and the Board of Governors will make the appointments after receiving the advice of an Advisory Appointments' Committee, consisting of persons nominated by the Board and the University of London.

In conclusion, the Bill is better than many of us feared. Although it is suggested in some quarters that the preferential treatment meted out to the Teaching Hospitals is more apparent than real and that the Teaching Hospital fly is being invited to walk into the parlour of the Ministerial spider, the fact remains that the Bill does appear to recognise the paramount importance of the Teaching Hospital in setting and maintaining the standards of Medicine in this country. In the Emergency Hospital Scheme the Teaching Hospitals more than justified the key positions that were assigned to them, and they took advantage of the opportunity provided by the war to extend their influence for the benefit of the community. Owing to the war Guy's was brought into close relationship with the Hospitals of South-East London and of Kent. Despite the abruptness with which these relations were opened, they were always friendly, and it seems certain that this connection will be strengthened by the National Health Service.

It would almost appear that we can look forward to the future of Guy's without undue apprehension.

We offer our congratulations to the Association Football Club on winning the Inter-Hospitals Cup for the twentieth time and for the third year in succession, and to the " A " XV on their successful season.

The Uneasy Child

A Clinical Lecture Delivered at Guy's Hospital on Monday, December 10th, 1945.

By T. B. LAYTON, D.S.O., M.S.,

Surgeon in Charge of the Throat and Ear Department, Guy's Hospital,

MR. SYMONDS used to teach that when a child had been in hospital for forty-eight hours it would not cry unless it was in pain. I have known him make a house-surgeon take down the elaborate system of splintage with which we then used to treat fractures of the leg and be proved right by there being some rubbing of the heel, and the crying immediately ceasing when the splints were readjusted properly.

Before we consider the teaching of Mr. Symonds a little more fully, let us think what we mean by the word "child." The New English Dictionary describes it as a young person of either sex below the age of puberty. My own feeling is that that is too narrow a definition, and it gives the suggestion of a sudden ending and a completely fresh beginning which does not happen in life. My own definition therefore would be: "A human being who has not yet reached full physical growth." I have always felt that Shakespeare compresses too many of his seven ages of man into the later years of life. Anatomy needs the whole seven for the growth period. First, the supine child, gazing at the stars and trying to clutch at them. Then the prone one, digging in the dirt of the earth. Next the toddler, venturing around the room and from that out into the garden. Then the young schoolchild, at first led to school, but subsequently going on his own initiative. After that there comes in the growth of what may be going to dominate or distress her or his life for the next forty or fifty years—the development of sex, the ages of which can be subdivided into three. Adolescence, where sex is beginning to develop, where you can see it happening, but where the child is quite ignorant of it. Youth, during which the child learns that sex is developing within himself, learns what it means, but has not yet learnt the necessity for control. Finally, the years in which sex is fully developed and the young adult should have learned the necessity for some degree of controlling it. During that time the new generation has begun to arise, and growth is starting afresh. Growth never ends but, in the individual, stops at about the age of twenty-four.

All these seven ages of childhood overlap, except at one junction where there is a rigid line drawn, and that line is made by man and not given by God. It is the time when the child goes to school. It is as rigid as that other line when presently the child "comes of age." That, again, is a line made by man, quite meaningless in the anatomy and physiology of the individual. We may tabulate these ages thus:—

THE SEVEN AGES OF GROWTH.

1. *The Supine infant* (to nine months).
2. *The Prone infant* (six to eighteen months).
3. *The Toddler* (first to fifth year).
   Artificial Rigid Date (fifth birthday).
4. *The Young School Child* (fifth birthday to eleventh or twelfth year).
5. *The Adolescent* (tenth or eleventh year to fourteenth or fifteenth year).
6. *The Youth* (fourteenth to seventeenth–nineteenth year).
   Artificial Rigid Date (twenty-first birthday).
7. *The Young Adult* (nineteenth or twentieth year to twenty-fourth year).

Synchronous with that complete growth there are two other things which are ending. One is mental. I believe that at about the age of twenty-four we reach the end of education. If by then you have not been "led out" by your teachers to think for yourselves you never will be. You may learn many more new facts, but unless you have by that time been taught to use those new facts and to amend your thoughts by them, you will stay in a groove for the rest of your life.

The other thing is that at that time the individual, being completely developed, has acquired his immunity. When we come into the world we have a certain amount

of protection against organisms, which is derived from our mother's blood. That is used up at somewhere about the age of eighteen months, and from then, by a series of small vaccinations from infections that we catch and develop, we reach our acquired immunity which becomes complete, if I am right, somewhere about the age of twenty-four. After that the individual's resistance may vary according to whether he is fit or ill, according to his mental state whether he is happy or full of anxiety. It may vary between one person and another, so that one always falls a prey to some particular organism and the other does not. But the acquired immunity is complete by then and not complete until then.

That is why I put down the age of twenty-four as the most important date clinically in the life of the human being, and, considered from the anatomical and physiological point of view, the one which is most definite and with the least overlap between previous changes and subsequent years. I will admit that this is all hypothesis, and it is very difficult to put into words the views and observations that have led me to this conclusion. But let me fortify my argument with quotations from Huxley :—

> "Do not allow yourselves to be misled by the common notion that a hypothesis is untrustworthy simply because it is a hypothesis."

And again :—

> "A hypothesis may do good work over a long period of time and yet finally prove to be quite wrong."

Let us go back to the teaching of Sir Charters Symonds. If we take the third and fourth of my seven ages of childhood, I think that he was right. You get a child admitted into a hospital, away from its mother. It cries. But the human being at that age is a wonderfully reactive animal, and at the end of forty-eight hours that child becomes happy and does not cry unless in pain. The older children get homesick. Homesickness comes on about a week later. They hide it and, if they are going to cry, they cry into their pillow, not allowing anyone else to know that they are doing so. But in the case of the toddler and the young school child that emotional upset, although very noticeable on leaving the mother, is likely to have died away in forty-eight hours. There are exceptions, and I think there are more exceptions to-day than there were when I was Mr. Symonds's ward clerk, If that is so I think it is due to the increased prevalence of what I would call the "uneasy child." That is a phrase that was given to me by a young lady with whom I started gossiping in a 'bus. I had never met her before, and I doubt very much whether I shall meet her again, and, if I do, I know I shall not know her. But I thank her for the expressive phrase which I have made the title of this lecture.

The "uneasy child" is quite different from the "solitary child" about whom Sir Robert Hutchison wrote so well. It is not the same as the "nervous child" whom Charles Cameron has described in his wonderful book. It is not the "neuro-arthritic" child about whom he has taught us. It is the child who will not settle down, who whines without crying, who sits up in bed and reiterates—"I want Mum. I want Mum. I want Mum." The child whom I remember repeating this most of all was a girl who, thirty-six hours previously, had been admitted to hospital unconscious from cerebro-spinal meningitis, and she was one of those examples of the miracles wrought by chemotherapy, which has given to medicine as great a change as Listerism gave to surgery—so great a change that it is difficult for people of my age to adjust ourselves to the new experiences that we are going through. It will be interesting to see whether the coming of penicillin will take the place of the sulphonamides in the same way as aseptic technique made the antiseptic technique out of date. In the case of this particular child it was not fair to take the forty-eight hours from the time when she was admitted to hospital. The time should be dated from the hour when she became conscious and well enough to sit up in bed, and by the management of the staff of the ward, doctors and nurses, that was successfully brought about.

The smaller child will be seen in the corner of its cot, standing up getting cold, and just crying out, "Mum ! Mum ! Mum ! " like the ticks of a metronome. When you approach at once it shows resentment. It waves its hand as though to hit you, which is the child's way of indicating that it does not want you. If then goes and lies down in the farthest corner of its cot with its head so turned that it can have a look at you when it is sure you are not looking at it, and it will keep that hand ready to swish around and slap you should you in your approach hold out your hand to touch it. Remember that that slapping of the child is not naughtiness. It is the same as the

gruff remark from an adult. The child cannot say, "I do not want to see you to-day," and it therefore attempts to slap you away instead.

Now, how are we going to deal with that child? There are three things which occur in the wards which make the handling of all children, and particularly these ones, very difficult. The first is that when a man is seen coming along most women pick up a child and hold it in their arms. Ostentatiously they bring the child towards you to give you a nice introduction. You observe that the child is beginning to smile at you, and then it will turn away and appear frightened. I believe that that is due to an atavistic instinct derived from Pithecanthropus erectus. When the male member of the incipient family came along and saw a number of sub-bairns, he was quite ignorant of the fact that he himself had had anything to do with their coming into the world, probably did not realise that any action of his was the cause of it, and certainly he was deficient of that altrusim which would cause the father to go without food for his children in time of stress. The female of the species then used to pick up her particular sub-brat in order to protect it from the member of the male sex who was coming along. It is time that the modern manifestation of that instinct should no longer be allowed to operate.

The next thing the woman does, supposing the child is in bed, is to go to the child and pull it about in some way, sit it up or turn back a wisp of hair that anyhow ought to have been controlled and not allowed to stray over the discharging ear. She will even look at the child's caudal extremity to make sure that it is "all right." That is a relic of the time when the doctor was a pompous fellow, a little tin god on a stick, and assumed an attitude that might be of value in the way of suggestion in the consulting-room to a patient with a lot of money, but was quite unsuitable to the attainment of any friendliness between doctor and child at the beginning of their meeting.

The third thing the woman does is to say, "Say good-bye, doctor" or "Say good morning, doctor." That is a relic of the time when children were supposed to be well-mannered, the period when manners made the man, the time when little children were seen but not heard. There are still some people who desire that to happen. I heard a distinguished gentleman over the wireless the other day summing up something in the Brains Trust by suggesting that the greatest thing wrong in the present day world was that children were so "ill-mannered." But when somebody introduces a child to you by that method it inhibits that friendliness of association that is so necessary when you are starting to deal with a person, especially with a very little person.

Of these three modes of behaviour the first and third are common to all women; the middle one is special to the nurse. In their preliminary training nurses should be taught not to do those things. We cannot influence that training, but we can let the nurses understand that that is not the way to handle children, and I hope that you will do so when you are doctors in the ward.

There is one other thing that is also done which I give you as a warning. Do not let the nurse wake the child, that you are going to see at night-time, in a hurry. There is a great tendency, as the doctor comes into the ward, for the nurse to seize a lamp and to shuffle along the floor in her slippers, take up the child, give it a shake, and throw the light of the lamp into its face. As the child wakes from a deep slumber it looks up and sees a great big jinn which it has never seen before. When I have remonstrated with a nurse for doing that she has replied: "But your time is important." I have replied: "Yes, my time is important. I gave up what I was doing after dinner; I put on my coat; I opened my garage; I started the car; I opened the gates; I drove the car out; I shut the garage and the gates; and I have driven ten miles and have come into the hospital. Here I have waited for the doctor in charge to talk to me about the case, taken off my hat and coat, walked down to the ward and got to the cot, and I shall have to do all that backwards again after I have seen the patient, and you have wasted the whole of my time because you have put this child into such a condition that it is impossible for me to give a proper opinion; and thereby you have not only wasted my time, but you have endangered the child's life."

The other place where you see a child is the consulting-room—whether it be an out-patient department, a clinic, a health centre or a private house. On this occasion you have got the mother to deal with, and when you see that mother you realise the meaning of the uneasy child. It is the mother that has made it uneasy. She is a good mother, a kind mother; she puts a lot of care into the upbringing of her child; she has earnestly studied it; she keeps it clean; she keeps the child under control. One wishes sometimes that she had not studied it quite so earnestly or kept it quite

so clean, because it is normal for a child to be dirty a quarter of an hour before its mid-day meal, and that she had not controlled it quite so completely, because the life of a child is a life of activity. She has the mentality of a sergeant-major. She raps out her commands, "Be quiet!" It is not that she says "No" two thousand times a day when five hundred times would be all that is necessary; it is the way she raps out that "No." Thus the child gets a reaction to the mother. The child knows that the mother loves it, it also loves the mother, but it is constantly on the look-out for those reproving words in the hope that it may avoid them. Thus it clutches the mother, hangs on to her, and starts to cry the moment you attempt to get it away from her.

With the supine and the prone child it may be right to examine it in the mother's lap. My experience is that when you get to the toddler and the older child you want to deal with the child yourself and not through the intermediary of the mother. The normal child is a matey little person, and if you can get "pally" with it in the first few seconds all will go well. Do not allow the nurse to usher the patients into the out-patient clinic. Do not have your clinic like the Temple of Sekmet at Karnak, pitch-dark except for one sharp blaze of light. And if you can avoid it never let the mother carry the child into the examination room. Hold out your little finger, let the child clutch it and hold on to it, and while you are talking to the mother and walking into the room you are gaining the confidence of the child. It is touch that does it. The child learns confidence in you from the feel rather than from the sight or the hearing of you. It does not matter how plain you are, or, in reference to the male sex, how ugly you are, so far as the child is concerned, or whether you have a small piping voice or a great huge boom, but it does matter if your movements are jerky as distinct from being smooth and therefore gentle. I think that in the stage of emotion such as a child goes through when about to be examined by a totally strange individual the child goes back to the sensations that first influenced him. The child first learns by the sensations of feel before he recognises the mother's or, possibly, the father's voice and before he has sufficiently developed binocular vision and accommodation to be able to see either of those persons other than as a blur, which is probably the first visual impression that he receives.

You can see the child happy in his mother's arms. He knows the feel of the mother's arms distinct from those of anyone else; then he begins to know the feel of his father's and of his aunt's. There are some people who can always nurse babies without ever having the child cry. My own father was one of them, right up to the day of his death. It was the gentleness of his movements and the fact that he was not jerky, which told with the child. There are some people who are smooth by nature in their movements, and there are some people who are jerky, but it is a thing that one can teach oneself and develop just as much as the sense of touch or the sense of hearing in percussion or auscultation.

Therefore you are beginning to get friendly with the child before you start to handle him. The more informal you are the better. The child hates formality. Do not put it on a revolving stool, but let it play with the stool. I have a series of positions for different children according to their size, and it is not until they have got so big that these positions are impossible that I set them down on the chair. That is at just about the age when the fourth of my ages is passing into the fifth, when the child, quite unconsciously, is beginning to object to sitting on a man's knee.

When you see this child in the ward you may find it standing up, legs apart, still crying out, "I want my Mum. I want my Mum," But it will very rapidly recover from that when its attention is taken by anything else, and by the time you have done a mere walk round the ward you may find that child perfectly contentedly playing with the other children and apparently quite forgetting its unhappiness at the absence of the mother. That unhappiness will return each time it sees the mother. In my opinion, that is one of the ways in which the nursing home is less good for the patient than the hospital. In the nursing home the patient is allowed to see visitors every day and all day. I remember one such child, the son of a dental surgeon—dental surgeons for some reason seem to be particularly unfortunate in the way they have uneasy children—who was in a nursing home in the West End. The father came up each day to see the child when he went to work; the mother came, too, and remained with the child until the father returned to fetch her for lunch, and then the father brought her back again in the afternoon and picked her up in the evening when he went home. Every time either of these parents came in the child would say, "What have you got for me?" and every time they brought some kind of present. He would

open this package with intense excitement, pick up the present, do something with it, and then lay it down on the bed, where it was entirely forgotten. That is the sort of behaviour on the part of parents which will foster the uneasy child, in addition to the machine-gun instructions that come usually from the mother, but not infrequently from the father as well, and when they come from both of them the child is made more uneasy than ever.

In order to avoid that sort of thing I always make a rule of talking at the child to the mother. When discussing operations such as having out tonsils I tell the mother that she will bring the child into hospital in the evening; that we shall operate in the morning; and that she will not come and see that child before the operation. "Oh, no," she will say, "I must come. Harry will be so upset if I don't." But I firmly insist that she must not even come to the door; she may telephone if she likes, though it will be quite unnecessary; and we will ring her up as soon as the operation is over, but she will not be allowed to come at that time; she may come at five o'clock in the evening to see the child for a moment or so. If you get that into the child before he goes under the anæsthetic he will go under calmly and quietly; otherwise this type of child will be a great nuisance on the operating table. You will have the child sitting up on the table making comments on everything, saying this is right and that is not right. Then, when all the arrangements are completed, he will say, "I want to pee"; whereupon the surgeon and the anæsthetist are sent out of the room, the nurse produces a porringer and, after a long time, the child manages to pass five minims of urine, after which the whole thing is started again.

There is nothing to do with that child except to take him firmly and gently, lay him down on the operating table and hold him there. Remember this: if you hold a child firmly but gently he realises by the sense of feel that it is no good struggling and he will then give up doing so. In the out-patient department or even the ward you have the same thing. Never let another person hold the child's head when mopping an ear. You have got to manage that child yourself. It is quite impossible to hold the head of a struggling child so rigidly that it cannot jerk fifteen degrees and if at the crucial point you diverge fifteen degrees from the external auditory orifice you will jab the meatal wall and hurt it. If someone else is controlling the child's head you cannot stop that jerk of fifteen degrees, and then you will be accused of jabbing the meatal wall; but if you are holding the child's head yourself you feel that jerk coming a split second before you do when the other person is holding it. Therefore you are able to relax your grip and the jab does not occur.

There are certain remarks about children that ought not to be made. One is, "The doctor is not going to hurt you, dear." You cannot stop the mother saying that, but you should be able to stop it from being said by the nurse or any other woman—or man for that matter—in your department. I think it is the cruellest thing ever done to a child—every bit as bad as boxing its ears. The child is quite a logical being; it sees you coming along; it is matey and wants to play. It says to itself, "This is not a bad old thing; I will get a little fun out of him." And then someone, whose confidence he is supposed to have, says: "It is all right, darling; the doctor is not going to hurt you." You can see the child saying to itself: "Why should he want to? Well, anyhow, I will play up and take jolly good care he doesn't." So he starts to resent and resist every single thing that the doctor tries to do. Remember this: the doctor may have to hurt the child. That was another of the teachings of Sir Charters Symonds, that it was necessary to hurt a patient for his own good. When you do so it is a matter of clinical judgment as to how much it is fair to do, and you should warn the patient that you are going to do it, and then hurt him less than the value of your warning has indicated. Even with children you can get them to go through a painful examination without any great distress unless they have been told by some adult that you are not going to hurt them. You should not lie unless you have got to, but if you have to lie, take care that you lie in such a way that the person to whom you have lied never finds you out. Therefore, never lie to a child because he will always find you out. So gravely do I disapprove of anybody saying: "All right, darling, the doctor is not going to hurt you," that I think in every case the one who says it, if she be a nurse, should be taken before the General Nursing Council with a view to considering whether she should not be struck off the Register!

There are two other words heard far too often; one is "naughty" and the other is "silly." Whenever an individual uses those words in the presence of the doctor it makes the examination more difficult. You should never use the word "naughty" to a child unless he has done something that he, with his mental development, knows

that he should not have done. If a child is playing with something and drops it on the floor and breaks it, that child is not "naughty." If it was something of value it should have been taken out of his hands and put in a safe place, and if it was something of trivial value, what does it matter compared with the developing brain of a little child? The other way in which the word "naughty" is constantly used, particularly with smaller children, is in reference to excreta. The child is called "naughty" because its bowels have been opened before the nurse gets to it, in spite of the fact that it was given some rhubarb the night before, and in spite of the fact, while the nurse is talking to the doctor, that it has been grunting hard, which is the method it has been taught to warn them that its bowels are going to be opened, and then when it happens it is called "naughty."

The word "silly" is almost as bad. The word is used for something that you think trivial and below your dignity. But it is not trivial to the child; it is frightfully important. It is the way in which that child is learning to decide what is important in life and what is not. He finds out later that the little bits of paper he has treasured up are really valueless, and that his mother's pearls, real or sham, which have been scattered over the floor because the rope broke, are really quite valuable things. But at the time when he is experimenting with these things his enthusiasm for some brightly coloured bit of paper is perfectly logical. It is not "silly," nor is it "naughty" if he does not realise that the rope of pearls is of considerable monetary value.

This condition, which I have called "the uneasy child," is not pathological. It is not a diathesis. It does not suggest any mental deterioration, and I do not think that it leaves in the child any harm when he grows up. But it is of great importance to the doctor who is trying to carry out an examination, particularly in diseases of the ear and throat. I would suggest that it is a disharmony of the mother-infant relationship. I would ask you to observe, and to observe, and always to observe in order to discover for yourselves how much I have told you to-day is the truth and how much is entirely wrong.

The Wildernesse at War

By C. F. HAWKINS, M.R.C.P., Resident Medical Officer.

GUY'S U.S.A. HOSPITAL was opened on June 30th, 1941, to alleviate the shortage of beds at Guy's created by the "Blitz" of the previous few months. This was made possible through the generosity of Mr. G. E. Fawcett, who leased the greater part of his famous country club to the Hospital at the rate of one shilling per annum; and the trans-Atlantic flavour of its title was a tribute to the substantial and timely help sent from America. The Hollywood Branch of the "Bundles for Britain" Fund not only gave a large sum of money, but also a great deal of the equipment. The interest shown by individual film stars will long be remembered by the instruments that they presented with their name engraved upon them, and one only had to enter the operating theatre or see the magnificent new deep X-ray plant to appreciate the great generosity of these people.

It would be pretentious to attempt to justify this article by a description remotely resembling that of Guy's or other of the Sector hospitals, where direct hits were not infrequent and dangers greater. No, the story in this case is of the conversion of a beautiful and imposing country mansion, standing resplendent amidst the hilly country to the north of the Kentish Weald, and partly dating from the seventeenth century, to an emergency hospital. This sanctuary of golf, billiards and bridge was, not without difficulties, changed into an Annexe of Guy's, although a section of the club still remained for the use of club members. This strange union has now been dissolved, as the building was handed back to its owner on December 31st, 1945; and so the sanctity of the billiard-room where Sister Gale kept a cheerful discipline over the military patients very reminiscent of Astley Cooper of pre-war days, has now been restored to the colonels; and quiet again pervades the panelled dining-hall, rudely disturbed by the children, whose faces had been restored and palates bridged by the plastic surgery that was a constant feature on the agenda of the operating theatre.

Perhaps, at times, the presence of the Borough patients in the gilded rooms with their fine ornate ceilings seemed incongruous, but they enjoyed it. It was a rest from the bombardment of London and a change for them to gaze upon the terraced grounds after the walls and rubble of Southwark. There were some who were appalled by the din at night provided by the concentration of the A.A. units in the neighbourhood, and longed to return to the quiet of the underground shelters, but these were few, and their equanimity was speedily restored by a liberal exhibition of brandy. Others, it is rumoured, gazing in their post-anæsthetic d lirium upon the paintings above them, had to be reassured that their operation really had been a success.

The one hundred and twenty beds at Seal, as well as acting as an overflow from Guy's after air-raids, were filled with a mixture of medical and surgical cases under Dr. Hampson and Mr. Eckhoff. A number also were reserved for Mr. Carter-Braine's cases of neoplasm and other conditions requiring deep X-ray therapy. Altogether 4,560 cases were treated here, and amongst these there were 2,234 operations. The group of single rooms leading from the balcony at the top of the main staircase was well suited for the use of private patients, whose accommodation was so limited during the war, and here, also, members of the staff, both medical and nursing, were restored to health under, dare one say, ideal conditions.

The only time when The Wildernesse really felt itself in the war was when it spent a precarious time amidst the forest of steel cables forming the balloon barrage that helped to protect London against flying bombs. The building was a prominent one with enormous windows of plated glass, and much time was spent in trying to decide upon the safest beds. The 281 mgm. of radium, which, if scattered over the country-side, would have provided a complex problem, were removed to a better place and, wherever possible, tubes of radon gas were used instead. The flying-bombs came over; many penetrated the barrier with a supreme contempt; others struck a cable and pursued their course recklessly until the ominous silence of their engines heralded their final dissolution. One or two struck the balloon itself and the combined explosion was great. This was a time of anxiety by day and by night, yet, in spite of some serious hits near by, the hospital remained untouched and continued so throughout the War.

Many factors contributed to make this branch of Guy's a success. There was, in particular, Miss Bell, the lady superintendent, whose personality was well suited to hold responsibility and who overcame many difficulties by her tact and charm; also Mr. Kilpatrick, Mr. E. R. Davies and others, who, without warning, undertook charge of the administrative as well as the medical side of the hospital.

Great tribute is also due to Mr. Fawcett and his staff, especially Miss Dunn and her sister, who gave their willing co-operation and spared no effort to assist the hospital.

There will be many, both medical and club members, who will remember the association with a certain affection, and, not the least, those Borough patients who were given a brief respite at The Wildernesse from their grim surroundings.

Correspondence

"SYRINGE SERVICE AT GUY'S."

To the Editor of the GAZETTE.

SIR,—Messrs. Anderson and Bligh will be glad to know that the Medical Committee have already agreed to the formation, not only of a syringe service at Guy's such as they, very properly, suggest in their letter, but also to a central supply for all apparatus that could be more efficiently sterilised than is at present the custom. The details are even now being worked out.

I am, Sir,

R. C. BROCK.

Guy's Hospital, S.E.1.

Sport

Rugby

GUY'S *v.* ROTOL (GLOUCESTER).

(*At H.O.P. on Saturday, March 30th*, 1946.)

Result: Guy's, 3 pts; Rotol, 6 pts.

The end of the season lethargy was much in evidence when Guy's were defeated by the very keen Rotol side by 2 tries to a penalty goal. Shortage of players meant placing a queer-looking team in the field, with J. Keeling and M. Hatton, normally forwards, playing at centre three-quarter. Never at any stage of the game did Guy's look like scoring: the passing was hurried and Van der Westhuizen, at stand-off half, carried out several delightful individual runs, without, however, linking up with his backs. The forwards played reasonably well, but the lack of determination all through reduced the game as a spectacle to a very ordinary affair.

Guy's had a number of chances with penalty kicks, but T. L. T. Lewis was not in his best kicking form and missed from fairly good positions, although he managed to land one towards the end of the game in front of the posts.

Rotol held a half-time lead with tries by E. Pryse and H. Hawkins and came close to scoring on several other occasions, but they too, were unable to finish.

"A" XV.

SUMMARY OF THE SEASON, 1945–46.

Played.	*Won.*	*Lost.*	*Drawn.*
17 ..	11 ..	5 ..	1

Points: For, 236; Against, 98.

D. F. POTTER,
Captain.

Association

INTER-HOSPITALS CUP.

Guy's obtained a bye in the first round.

Second Round.

GUY'S *v.* ST. MARY'S.

(*At Teddington, Saturday, February 10th*, 1946.)

Result: Won 6–3.

Semi-Final.

GUY'S *v.* LONDON.

(*At Hale End, Saturday, March 2nd*, 1946.)

Result: Won 4–3.

In conditions of wind, snow and rain it could not be expected that the standard of football in this game would reach a very high level. Nevertheless, by defeating a strong London team Guy's proved themselves equal to the occasion.

With the wind in their favour Guy's attacked hard in the first few minutes, but made little impression. The London forwards soon retaliated with a series of very strong attacks. After several fine clearances by Busbridge play settled in the London half of the field. Newton, at wing-half, was always conspicuous in supporting the forwards and, although he gave many fine attacking passes, little use was made of them.

After thirty minutes, however, Guy's took the lead, when Merrill, being well positioned, received a pass from the right-wing and promptly shot into the net. A few minutes before half-time Guy's scored again, when Leckie forced his way through.

Within thirty seconds of the kick-off after the interval Sykes had scored a third goal for Guy's. The ball moved so swiftly between the three inside forwards that the first London player to touch the ball was the goal-keeper, who removed it from the back of the net. As the second half progressed the weather deteriorated, the strong wind being particularly troublesome to the Guy's defence. The London team pressed home their advantage and succeeded in scoring two quick goals. Guy's retaliated, however, fifteen minutes from the end, when Leckie scored again after a fine individual effort. In the last few minutes London brought every man into the attack and scored another goal.

Team.—I. L. Busbridge; K. Sunnaway, R. A. C. Dove; E. M. Newton, H. R. C. Riches, A. Robertshaw; R. K. Foster, M. J. L. Sykes (captain), J. C. Leckie, A. E. Trist, A. R. Merrill.

The Final.

GUY'S *v.* ST. THOMAS'S.

Result: Won 4–1.

On Saturday, March 30th, 1946, at Imber Court, Guy's won the Inter-Hospitals Cup for the twentieth time and for the third year in succession. By defeating a strong St. Thomas's team so decisively the team has maintained the supremacy of Guy's in Inter-Hospitals Association football.

From the kick-off the ball was taken well into the St. Thomas's half. In the opening phases Leckie, Trist and Sykes were prominent, but gradually, however, play shifted to the wings. Owen and Foster gave great trouble to the St. Thomas's defence, but found difficulty in finding the proper man with their centres. This was unfortunate, and had it not been so Guy's would have scored very quickly. For long periods Guy's were attacking with only occasional replies from St. Thomas's; indeed, at this stage of the game the opposing forwards were completely subdued.

After fifteen minutes Guy's took the lead. Leckie received the ball on the edge of the penalty area, beat two men who converged on him, and shot hard into the corner of the net. St. Thomas's rallied after this goal, but, although they forced two corner-kicks, Busbridge, who was playing splendidly in goal, was never really worried.

Guy's went further ahead after half-an-hour, when Leckie beat the goalkeeper to the ball after a scramble in the St. Thomas's goal-mouth. Our opponents were not disheartened by this and the closing moments of the first half were the hardest of the whole game for the Guy's defence. On several occasions Busbridge was called upon to make fine saves, and it was only by hard determined play that Guy's were able to change over with a lead of two goals.

After three minutes' play in the second half Leckie scored a third goal for Guy's. Great credit for this goal must be given to Trist and Sykes, who, by excellent approach work, gave Leckie his opportunity. For a period after this play was mainly mid-field with neither side making much real progress. But Leckie could not be subdued for long, and soon he had scored once more. Guy's were now in a very strong position and, although the forwards still persisted in their attacks, the responsibility for the game now rested with the defence. Jones and Dove proved themselves masters of the situation and only one goal was conceded—in the last minute of the game.

Team.—I. L. Busbridge; D. G. Jones, R. A. C. Dove; E. M. Newton, H. R. C. Riches, A. Robertshaw; R. K. Foster, M. J. L. Sykes (captain), J. C. Leckie, A. E. Trist, R. Owen.

SUMMARY OF THE SEASON, 1945–46.

Played	*Won*	*Lost*	*Drawn*
23	10	11	2

Goals: For, 84; Against, 74.

J. C. Leckie, a freshman, scored 53 goals during the season.

Hockey

GUY'S *v.* MIDDLESEX HOSPITAL.

(*At H.O.P., Saturday, March 2nd*, 1946.)

Result: Lost 6–1.

This was the semi-final of the Hospital knock-out competition, Guy's having been given a bye and a walk-over in the first two rounds. In the beginning we pressed hard, undaunted by the abominable weather, but gradually the occasions when our opponents broke away became more numerous and less effectively repelled. We prevented many goals in mêlées round our goal-mouth, but Middlesex scored two by half-time.

When the second half began we again kept the ball mainly in our opponents' half, and a neat shot by Kelsey Fry made the score 2–1. Unfortunately, Middlesex rallied and immediately ran through our defence to score again. Thereafter the determination of our inside forwards was given little opportunity, and our defence was penetrated three more times by our opponents, whose ball-control and staying power were less impaired by the weather than our own.

Team.—F. H. Walker, H. Backhouse, L. D. Carton-Kelly (captain), J. B. Harris, H. W. Trusted, C. A. Jenkins, I. Kelsey Fry, A. E. Doyle, K. Y. Khong, R. L. Barnard.

Hospital Information, etc.

Pass List

CONJOINT BOARD.

FIRST EXAMINATION.

March, 1946.

Physiology.

H. E. G. Dyer — D. S. Noble
S. S. Grove

Pharmacology.

P. Coling — J. S. G. P. Stableford
E. J. F. Filòse — J. G. Stebbing
G. A. Kerr — R. L. Timms
R. A. Parker — C. Waller
P. Read

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS.

Diploma in Obstetrics.

J. Kenworthy Ogden.

CAMBRIDGE UNIVERSITY.

Examination in Pharmacology.

March, 1946.

M. Caller — M. P. Ward
P. J. Higgins — A. R. H. Worssam
M. G. Kaye

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

March, 1946.

Pathology, Bacteriology and Forensic Medicine.

*K. R. Brookes

Midwifery.

*K. R. Brookes — *E. H. Osborn-Smith

* Have completed the examination.

Papers by Guy's Men

Brooke, R. Fractured patella: an analysis of fifty-four cases treated by excision. *Brit. Med. J.*, 1946, i, 231.

Lyth, Oliver. Endemic Fluorosis. *Lancet*, 1946, i, 233.

Clarkson, Patrick, and Others. Treatment of 1,000 jaw fractures (*cont.*), *Brit. Dent. J.*, 1946, **80**, 107.

Cohen, Sol. M. The Surgical management of peripheral vascular disorders. *Post-Grad. Med. J.*, 1946, **22**, 1.

Maizels, Montague. The action of hæmolysins on normal and pathological human erythrocytes. *Quart. J. Exp. Phys.*, 1946, **33**, 183.

Cushing, R. W. A Survey of the activities of the Military Isolation Hospital, Aldershot, 1939-1945. *J. Royal Army Med. Corps*, 1946, **86**, 12.

Irving, J. T. A comparison of the action of Vitamin D on the teeth of rachitic rats with that of additional calcium or phosphorous added to rachitogenic diets. *J. Phys.*, 1946, **104**, 253.

Ambache, N. Interaction of drugs and the effect of cooling on the isolated mammalian intestine. *Ibid.*, 266.

Grant, R. T., and Others. Thomas Lewis. *Brit. Heart J.*, 1946, **8**, 1.

Graham, A. J. P. A simple apparatus for Penicillin Administration. *Brit. Med. J.*, 1945, ii, 768.

Reading, Philip. Some observations on the etiology of foreign bodies in the œsophagus. *J. Laryng. & Otol.*, 1945, **60**, 246.

Knott, F. A., and Shuttleworth, G. W. The significance of dental infections. *Practitioner*, 1946, **156**, 168.

Knott, F. A., and Blaikley, J. B. Penicillin sprays and upper respiratory tract infection. *Brit. Med. J.*, 1946, i, 349.

Ogilvie, Sir Heneage. Recurrent dislocation of shoulder. *Ibid.*, 362.

Cohen, Sol M. Surgical management of peripheral Vascular disorders. II. Vascular trauma. *Post. Grad. Med. J.*, 1946, **22**, 50.

Townsend, C. G. Anæsthesia for the Surgery of peripheral Vascular disease. *Ibid.*, 67.

Clarkson, Patrick. Treatment of jaw and face casualties in the British Army. *Ann. Surg.*, 1946, **123**, 190.

——— and Others. The treatment of severe prognathism by Kastecka's operation. *Brit. Dent. J.*, 1946, **80**, 186.

Hall, H. D. School dentistry in West Sussex. *Ibid.*, 192.

Vertue, H. St. H., and Gration, Hilda. Influenza. *Nursing Mirror*, 1946, **82**, 403.

James, D. W. Intestinal obstruction during late pregnancy. *Brit. Med. J.*, 1946, i, 485.

Robin, Ian G. Hearing aids. *Medical World*, 1946, **64**, 200.

Jacoby, N. M., and Sagorin, L. Osteomyelitis of the jaws in infancy treated with penicillin. *Arch. Dis. Child.*, 1945, **20**, 166.

Cameron, H. C. Pains in the legs in Children. *Clin. J.*, 1946, **75**, 48.

Bowen, W. H. A case of Anuria. *Ibid.*, 52.

Flower, Norman. An epistiotomy director. *Lancet*, 1946, i, 464.

Douthwaite, A. H., and Waterfield, R. L. Resistant anæmia, a note on the differential diagnosis of pernicious anæmias and familial acholuric jaundice. *Brit. Med. J.*, 1946, i, 519.

Colbeck, J. C., and Others. Temporal arteritis: a generalized vascular disease. *Quart. J. Med.*, 1946, **15**, 47.

Dowling, G. B., and Others. Lupus vulgaris treated with Calciferol. *Proc. Roy. Soc. Med.*, 1945–6. **39**, 225.

Douthwaite, A. H. The early recognition of disease. IV. Digestive Disorders. *Practitioner*, 1946, **156**, 307.

Appointments

Dr. J. M. H. Campbell will deliver the Lumleian Lectures at the Royal College of Physicians of London on Tuesday and Thursday, April 16th and 18th, 1946, at 5 p.m. His subject is "The Paroxysmal Tachycardias."

Change of Address

P. W. Clarkson, M.B.E., F.R.C.S., 22, Harley Street, W.1 (Langham 4351): 4, Westbourne Terrace, W.2 (Paddington 2962 (private).

H. C. Davis, L.D.S., St. Anne's Manor, Salisbury, Wilts.

J. M. Hanson, Surg.-Lieut., R.N.V.R., H.M.S. *Ferret*, Londonderry.

S. Holms, L.D.S., R.C.S., 40, Harley Street, W.1. (Tel. Langham 1011.)

F. L. Ingram, M.R.C.S., L.D.S., 2, St. Leonards Road, Thames Ditton. (Tel.: Emberbrook 3491.)

J. Kenworthy Ogden, M.R.C.S., D.Obst, R.C.O.G., The Maternity Hospital, Watford. Herts.

R. David Plowman, L.D.S., 2, Park Crescent, Portland Place, W.1.

Oliver Plowright, M.B., B.S., 21, Church Row, Hampstead, N.W.3. (Tel.: Hampstead 1014.)

G. W. D. Reeves, M.R.C.S., L.R.C.P., Pentre, Porthlever, Helston, Cornwall.

H. Richards, M.B., B.S., Sudan Medical Service, Khartoum.

Douglas Saunders, Surg.-Lieut., R.N.V.R., H.M.S. *Simbang*, S.E.M., Sawang, Singapore.

Births

DENTON.—On March 8th, 1946, at Benslow Nursing Home, Hitchin, to Edith (née Luer), wife of Sqdn.-Ldr. P. H. Denton, R.A.F.V.R.—a daughter.

ELLIS-BROWN.—On March 11th, 1946, to Ann, wife of Dr. R. Ellis-Brown—a brother (Vincent John) for Kathleen, at Richmond, Surrey.

GRUMMITT.—On January 8th, 1946, at Guy's Hospital, to Olive (née Chase), wife of Surg.-Lieut. (D.) P. C. Grummitt, R.N.V.R.—a son (David Marshall).

HIND.—On April 4th, 1946, at Guy's Hospital, to Margaret (née Fearnehough), wife of A. W. Hind, Capt. R.A.M.C.—a daughter

PORTER.—On March 25th, 1946, at Guy's Hospital, to Phil (née Richardson), wife of W. A. Porter, Ft.-Lt., R.A.F.—a son (Richard William).

Deaths

BLIGH.—On March 25th, 1946, at his home, 21, Dunkeld Road, Bournemouth, William Bligh, O.B.E., M.D., late of Caterham Valley, Surrey, aged seventy-eight years.

BYFORD.—On March 13th, 1946, peacefully, at 19, Sussex Mansions, Brighton, William Francis Byford, M.R.C.S., L.R.C.P., formerly of Ruthin, North Wales.

MARSHALL.—On March 15th, 1946, at Wishaw, Lanarkshire, Thomas Burn Marshall, M.B., C.M..

GARNER.—During March, 1946, William Langham Garner, M.B., B.Ch., of 55, Rufford Gardens, Southbourne, late of Ampthill, Beds., in his seventy-seventh year.

EDS. {J.M.H. R.H.N.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

Of making many books there is no end; and much study is a weariness of the flesh.
ECCLESIASTES, xii, 12.

THIS is the Book Review number. It may not appeal to all our readers, but we have much pleasure in presenting it. The date of publication could scarcely have fallen at a more opportune time. The summer term is just beginning and those whose life is no longer bound by terms and vacations have recently returned refreshed, we hope (the weather, at least, seems to have been universally agreeable), from their Easter recess. In due course their thoughts may be turning to books.

The war did not succeed in bringing about any deterioration in the level of book production; both authors and publishers, often labouring in discomfort, and, perhaps, at times, tasting despair, maintained a standard already high and even improved upon it. Medical books have to keep abreast of modern views and the regularity with which fresh editions, and entirely new works, appeared in circumstances far from propitious was commendable as well as satisfying.

The number of books on medical subjects increases with the years and so, too, does the problem of sifting the wheat from the chaff. The excellence expected in a modern work tends to limit the quantity of thoroughly bad books to reach the booksellers' shelves. Nevertheless, the market in some branches of medicine is, if not quite flooded, adequately waterlogged. All the books may be basically sound, all equally expensive, but some must obviously be more suited to their purpose than others. It is here that the reviewer can help us.

He may not be able to help us very much; very little if his review happens to differ fundamentally from that of another man just as competent and just as honest. But the responsibilities of a reviewer are not to be taken lightly, for the results of his labours may be far-reaching, although it would be hard to assess the extent or the value of his influence. A student may buy a book simply because it looks good or because it stands a reasonable chance of being good and a sure way of finding out is to buy it and see. Some students never buy a book at all. This *Gazette* is aimed at helping those who are persuaded in their choice of a book by the opinions of others. They constitute the majority; it may be a substantial majority.

It is possible that they will have to weigh one review against another, but it is gratifying to find how similar two reviews of the same book usually are—in contradistinction to two reviews of the same film, which are frequently diametrically opposed. A practical and balanced review, unencumbered with an effusive padding of praise or condemnation, is a great asset to the prospective buyer and, even if the book is not a success, to the author and to the publisher, who will know what to put right in the next edition. Such a review is difficult to produce. The Rev. Sydney Smith found it impossible; he declared, characteristically, "I never read a book before reviewing it; it prejudices a man so." We can confidently assert that this novel approach to the art of reviewing books is not one regarded with much favour by contributors to the *Gazette*.

The following pages contain reviews of the latest editions of several familiar works, a few less familiar ones, and some entirely new monographs as yet unknown and unproved. Much study of a good book may lead to a weariness of the flesh; but it would be a pity to overlook the stimulus to the mind and the reviving of the spirit which accompany it.

My only books
Were woman's looks,
And folly's all they've taught me.

THOMAS MOORE.

. . . . which reminds us that nurses are wearing their strings again and, while it is untrue that all pretty nurses have strings, it must be admitted that all nurses with strings are slightly pretty. We are all glad to see this old and becoming custom introduced once more. It has already added a breath of feminine charm to the warm spring breezes. Appreciation of a refreshing and artistic effect will, no doubt, serve as an antidote to folly.

WE are glad to announce the re-opening of the College. This building suffered heavily from bomb damage and, considering the difficulties that had to be met, those in charge of rehabilitation have done exceedingly well. Most of the rooms will be occupied by House Officers (transferred from Doyle's), but some are available for students. The colour scheme alternates tastefully from primrose to green and the furnishings are fairly adequate. Parts of the building, including the Pavy gymnasium, are not in use. Those in residence will feed in the College dining-room. With the return of the Medical School the congestion here will again be great, and the time spent in search of lunch will change from minutes into large fractions of an hour for those unable to join the queue by a quarter to twelve.

THE Hospital benefited to the extent of £4,500 as a result of Matron's appeal towards the end of last year.

REPRINTS of Dr. Campbell's article—" Orpington, 1939–1945 "—are now ready and may be obtained from the *Gazette* office, price 1*s.* each, postage extra.

We learn with deep regret, on going to press, of the sudden death of Mr. John E. Humphery, our Treasurer, and a Governor of the Hospital since 1917.

Lupus Vulgaris

By L. FORMAN, M.D., M.R.C.P.

A Clinical Lecture delivered at Guy's Hospital on Tuesday January 22nd, 1946.

GENTLEMEN,—Lupus vulgaris is a chronic inflammatory disease of the skin, with a tendency to ulceration, scarring and healing, caused by the tubercle bacillis, bovine or human.

The disease has its maximum incidence in the poorer sections of the community, and its incidence and severity have been largely influenced within the last two decades by various social measures initiated by communal and by local and central governmental action. Certainly in twenty years the number of cases seen in dermatological clinics has been diminishing, but it is important to be able to recognise the early appearances of lupus, as with other forms of tuberculosis. The early tuberculous lesion yields to treatment, but the well-established infection involving a larger area of tissue, be it lungs, glands or skin, is a much more formidable proposition and bears the increasing risk of wider dissemination and a possibly fatal outcome. You are all aware of the increased incidence, as a result of war conditions, of tuberculosis of the lungs. This must entail a parallel increase of tuberculosis of other tissues, including the skin.

The tubercle bacillus may be inhaled in droplet or dust, ingested with infected milk or food, or be directly inoculated into the skin. The methods used to diminish the transmission of the disease over the past forty years are as follows :—

1. The reduction of overcrowding in houses, so as to diminish the risk of infection of children and young adults by individuals with open foci.
2. Segregation and education of tuberculous individuals to enable them to avoid infecting others.
3. Control of slaughter-houses and supervision of carcases.

4. Attempt to rid herds of tuberculosis by giving bonuses on the milk from a tubercle-free herd.
5. School medical services trained to detect early signs of tuberculosis and to supervise known contacts.
6. Miniature radiography has been used to examine large numbers of individuals in the Services and factories, and unsuspected early and chronic cases have been detected.

War conditions undid much patient work. At the beginning of the war sanatoria were cleared to provide beds for casualties, and some patients with open tuberculous foci were sent back to their families. Shelter life gave ample opportunities for infection, and it was only after a time that it was possible to seclude people with obvious respiratory infection. There was overcrowding in houses and shelters. The separate marketing of tubercle-free milk ceased in most areas, for all milk was bulked. The greater volume of milk was pasteurised, but not all.

Lupus vulgaris is a comparatively late manifestation of infection, for it implies, by its chronicity and its tendency to heal, a considerable immunity to the bacillus. The multiplication of the tubercle bacilli in the granuloma is inhibited ; they are only few in number and the effect on the skin is limited and kept within bounds.

The bacilli may reach the skin by way of the blood from a tuberculous focus in the lung, gland or bone, producing a skin lesion often single but sometimes multiple. The latter not infrequently follow an infection—*e.g.*, measles—which activates and softens a lung focus, allowing large numbers of bacilli to enter the bloodstream. Those caught up by the skin capilliaries are at least away from organs vital to life and the diseased skin is readily available for treatment, but other bacilli may lodge in more significant structures—*e.g.*, bones, joints, kidneys and meninges.

The first two illustrations, which were taken in 1944, are of a boy of four years. He was a vigorous, plump, healthy-looking child. A year before he came to hospital he had had measles and a month later had tender nodes on the shins which were thought to be rheumatic, but may well have been erythema nodosum. The lesions shown in the photograph were said to have occurred a month later. On the right thumb he had a reddish-brown, raised plaque, a centimetre across, covered by an adherent horny mass. The little finger showed similar areas, more horny and also warty. On the heels, soles, knees and elbows there were warty patches up to 3cm. in diameter. In February, 1945, he was found to have a stiff back. X-ray showed disease of D. 10. He was taken into hospital and put into a plaster cast. In March, 1945, in died and post-mortem showed caseous lymph nodes at the bifurcation of the trachea, no abnormality in the lungs, and D. 10 almost destroyed. There was a large psoas abscess and tubercular meningitis.

The individual lesions in the knees showed the somewhat congested, brown colour of lupus vulgaris on the limbs, but the characteristic translucency on glass compression was not detected. The wartiness of the lupus patches in this child was caused by the hypertrophy of the epidermis over the granuloma in the cutis.

The most frequent age of onset of lupus vulgaris is from five to fourteen years.

The next illustration is of a patient with a more extensive single area of lupus vulgaris on the face ; the face and distal parts of the limbs being the most common sites to be attacked. This patient also showed lupus affecting the mucous membranes, which occurs in 50 per cent. of lupus cases, and illustrates the way in which the skin of the face is involved by spread from the mucous membranes of the nose and mouth. There was the complication of secondary infection with increased destruction of the skin, fibrocartilage and cartilage.

He was first seen in September, 1944, when he was thirty-three years old. At the aged of twenty-seven he had lost his voice and was found to have lupus of the pharynx, which was curetted. The X-ray of his chest was said to be negative. When aged thirty-two he had scaling and crusting inside the nose and the skin of the upper lip was affected. In 1944 he showed lupus vulgaris of the nostrils, upper lip and nose. The upper lip was swollen and the skin was scarred. Small areas of lupus, brown in colour, were to be seen, and glass compression showed the light brown translucency of a granuloma. Small nodules were to be seen within the scarred zones. The palate and pharynx were scarred and his voice was husky. Mr. Cam thought he still showed active lupus of the anterior part of the palate. X-ray of the chest showed evidence of old disease of one upper lobe. He did very well with two months' treatment with the Kromayer lamp and small doses of X-rays to the ulcerated areas.

Lupus vulgaris not infrequently appears first in the nasal mucosa; the organism may gain entrance through an abrasion. The source of the infection may be inhaled dust or contaminated hands, particularly if there is a habit of picking the nose. The granuloma then spreads by continuity and also along the lymphatics and appears on the outside of the nose and upper lip.

In this patient there is destruction of the left alæ nasi. Lupus has a tendency to ulcerate, owing to the avascularity of the granuloma. The epidermis stretched over the granuloma takes part in this necrosis and breaks down. This allows of the entry of other organisms which aid in the destruction of tissue; thus staphylococci give rise to abscess formation and streptococci, besides causing local reactions, *i.e.*, cellulitis, may involve the lymphatics. Thus, besides the acute complication of erysipelas, permanent blocking of the lymphatics may occur with marked swelling of the affected areas. Lupus of the skin of the foot may give rise to elephantiasis of the lower leg.

A similar but more extensive case is illustrated next. Miss H. A. was seen at the age of twenty-five years. She gave a five years' history of her skin affection.

Ten years previously she had had osteomyelitis of the foot which now shows destruction of the first metatarsal. It is very likely that this patient had involvement of the mucous membranes for some years before she noticed the skin changes. The illustrations show the dull, brownish-red infiltration of the upper lip and adjoining cheeks and nose, with destruction of the alæ nasi. Obviously the disease had spread from inside the nose. The gums were dark red, the mucous membranes were thickened with papillomatous projections, and the same changes were noted around and between the teeth and on the hard palate. The left conjunctiva was also congested, indicating spread of lupus up the tear duct.

The next patient is elderly and illustrates the chronicity of lupus. She is a lady æt. 60 years in good health. She had had the condition since childhood. Up to the age of thirty or forty it had never been more extensive than a lesion 3 cm. across. In 1944 she showed extensive involvement of the left side of the face and neck. A scar could be seen under the left chin, suggesting that the skin had been infected by tubercle bacilli from an underlying gland as it softened, suppurated and discharged. The colour of the affected skin was brown, the surface soft, and glass pressure revealed the characteristic colour of the infiltrate.

Infection of the skin with the bacilli, although most frequently seen in childhood or young adult life, may occasionally obtain in late middle age or old age. You will recall the senile tuberculosis of lungs, bones and joints. Immunity may be lost in old age, and there can be reactivation of an old focus present for many years and safely walled up with fibrous tissue. This is illustrated in the following case.

Mrs. B., aged fifty-six. When first seen she had had a granuloma of the left nostril for two months. There were nodules on the face and angles of the mouth, symmetrically placed. Some of the nodules had broken down. The arrangement of the lesions, their necrosis and short history suggested tertiary syphilis. X-ray of her chest showed fibrosis at the right apex and left upper lobe suggestive of old tuberculosis.

The ulcerated areas cleared up and the nodules of lupus appeared, spreading rapidly over the cheeks, with involvement of the nose. In spite of treatment (not carried out regularly because of travel difficulties) the process has steadily advanced over the past ten years, affecting face and ears. Healing with scarring over wide areas of the cheeks and nose has occurred, but active lupus nodules are to be seen in the scar tissue.

Direct inoculation of the tubercle bacillus in to the skin of an individual with considerable immunity will give rise to the chronic, limiting granuloma of lupus, with the important difference that the resulting granuloma is in the upper part of the cutis directly beneath the epidermis. The latter will hypertrophy, giving a warty surface to the dull red and cyanotic thickening of the skin. This condition is given the following names, indicative of the possible circumstances of infection—*Tuberculosis verrucosa cutis*, *Anatomical Wart*, *P.M. Wart* and *Butcher's Wart*. There may be autoinoculation, the patient infecting his skin from his own sputum.

Mr. J. G., aged forty-three. He gave a two years' history of warty thickening of the thumb, depressed and scarred in the centre. The section showed a tuberculous granuloma. X-ray of the chest shows tuberculosis. The condition had followed a cut on the thumb. This patient was in the habit of picking at his skin.

The following cases illustrate a rare complication of lupus vulgaris. Mr. S., aged fifty-three. The condition began twenty-six years ago. When he was seen in 1945 he showed an extensive plaque of lupus vulgaris, centred by a large, projecting epithelioma which had been present two years. He had had no treatment for the lupus. No glandular enlargement was to be demonstrated, so that the epithelioma is relatively benign.

Mr. H. C., aged forty-one. At the age of twelve years this patient had tuberculous glands in the neck, and these were excised. About this time he was given two doses of X-rays to the area. It was also treated by scraping. He showed a scar under the jaw, suggestive of X-ray atrophy, and also had active lupus vulgaris in the scar. There was an epithelioma on the scar and an enlarged satellite gland.

Why does the skin become epitheliomatous ? The close association with a chronic inflammatory focus, the tendency to ulceration or secondary infection owing to interference with the blood supply, may well be enough to favour irregular growth of the epidermis. Prolonged therapeutic exposure to ultraviolet light, particularly X-ray dosage sufficient to produce atrophy of the skin, will increase the liability to carcinomatous metaplasia.

TREATMENT.

Early diagnosis and radical removal of the area of lupus, where possible, give the greatest promise of cure. Where excision is not practical, the aim is to destroy tuberculous granulation tissue with the minimum of scarring and deformity. Even where all diseased tissue has been removed it is necessary to observe the patient over a period of years for relapse may occur in the scar.

It should be remembered that, in common with tuberculosis elsewhere, there is a tendency towards self-healing, though usually incomplete. Treatment designed to raise the general resistance is therefore as important as local therapy, and includes a diet rich in animal fats and vitamins. The various methods of local therapy with their limitations are discussed in all text-books, and include curetting of the lupus patch, cautery, diathermy, and the use of chemical caustics thought to have a selective action on tuberculous granulation tissue—*e.g.*, pyrogallic acid, liquid acid nitrate of mercury, bromine, etc.

Local treatment with ultraviolet light, the method of Finsen and the various apparatus since designed to increase the intensity of light available, is capable in expert hands of producing excellent results with a smooth, healthy scar.

Ultraviolet light destroys the tubercle bacilli just beneath the skin. By compression of the skin to empty the capilliaries, light is able to penetrate more deeply into the substance of the granuloma and provoke a reaction of erythema and œdema which undergoes resolution and healing, due to the flooding of the zone with fresh lymph and inflammatory cells.

This treatment demands a special department with expensive apparatus, trained personnel and frequent attendances—it may be for a year. The economic factor frequently precludes such a prolonged course and leads to failure to cure.

General light baths, natural and artificial, have been found of considerable value, as with tuberculosis of bones and joints. Natural sun under controlled sanatorium conditions is preferable to the artificial light bath, but the latter, given regularly twice weekly, over a prolonged period, has given considerable benefit in cases of lupus vulgaris. The effect of the light bath is to increase metabolism and appetite and to stimulate the thyroid adrenal system, which is concerned with immunity mechanism. Further, light, by its actions on the dehydro-cholesterol in the skin, produces vitamin D. You will remember that fish oils, popular remedies for tuberculosis, contain vitamins A and D.

Dowling and others (*see Proc. Royal Society of Medicine, December, 1945*) have given large doses of vitamin D, calciferol, by mouth, up to 150,000 units a day (the usual therapeutic dose is 3,000 units daily). The argument behind this therapy is that the curative effect of light is associated with the production of vitamin D in the skin, and this beneficial result might be obtained by the oral administration of vitamin D.

The results in a series of thirty-eight cases, ages varying from thirty to sixty-five, have been startling and incomparably better than with any other method. In twenty-seven cases there was improvement and all these had been severe cases. In the other eleven cases, where little appreciable changes occurred, either the disease had been

masked by X-ray dermatitis or other sclerotic-producing therapy, and results were difficult to assess. One to three months' treatment produced very considerable improvement in the above twenty-seven cases, and at a demonstration (February 15th, 1945) to the Skin Section of the Royal Society of Medicine of six cases, it was agreed that the results were excellent, the lupus having disappeared with a minimum of scarring.

The effect of vitamin D by mouth is to increase the absorption of calcium from the gut, but the beneficial effects in lupus vulgaris do not seem to depend on a raised blood calcium. Thus, in Dowling's cases, after varying doses and periods of vitamin D, blood calciums were :—

Twelve cases	10.1 to 10.8 mg. per cent.
Three cases	11 mg. per cent.
Three cases	definite hypercalcæmia—*i.e.*, 12.6 mg. per cent., 13.8 mg. per cent. and 14.8 mg. per cent.

Vitamin D is a potentially toxic drug. It produces headache, irritability, nausea, vomiting, diarrhœa and polyuria. It may also induce a high blood calcium and phosphorus, and metastatic deposition of calcium in soft tissues—*e.g.*, arterioles of kidneys and medial coats of arteries. Renal changes, albuminuria and uræmia may follow, but these serious changes are reversible if the calciferol is stopped. Obviously cases requiring the above doses must be carefully watched.

If these results are confirmed there is new hope in the management of this chronic disease. It renders unnecessary the expensive and time-consuming treatment with light and will alter the outlook in most cases of lupus vulgaris.

Reviews

Elementary Anatomy and Physiology. By JAMES WHILLIS, M.D., M.S., F.R.C.S. Second Edition. J. & A. Churchill, Ltd. *Price* 15*s.*

THE wealth of basic knowledge essential for a good groundwork in both anatomy and physiology has been preserved in the second edition of this volume, and the subject-matter has not been altered to any great extent. It is clear and concise, yet full, and pleasant to read ; the classifications are logical and therefore easy to learn ; and good use is made throughout of smaller type. The illustrations are well drawn and simple, and some have been improved ; but the use of a little colour might help to clarify many more.

One addition and one alteration to the text are worthy of note. The very useful addition consists of a section on the use of muscles in the lower limb—lines which more senior students might well read with profit. The chapter on Metabolism has been revised and brought into line with modern views, but the benefit of this would appear to be partly lost by the occurrence of an unfortunate error in printing—one diagram being omitted entirely, and another captioned wrongly.

The other sections have remained practically as before, minor alterations only having been made—*e.g.*, the brief and elementary account of the "chloride shift" mechanism has been dispensed with entirely.

This volume is, in all, not only useful but essential to those in their second year of Medicine and, used in conjunction with lectures, will help to provide that sound foundation which is so necessary for the extensive study of scientific subjects.

M. W. J. G.

The Physiological Basis of Medical Practice. By C. H. BEST, C.B.E., F.R.S., and N. B. TAYLOR, F.R.S., F.R.C.S. Fourth Edition. Bailliere, Tindall & Cox. *Price* 55*s.*

THE fourth edition of this work in a period of ten years is a tribute, both to the ever-changing face of physiology and to the energy of the authors in holding it up to their medical audience.

From its inception this has always been a useful book for students of medicine. Its avowed object was "to give the students and practitioners a vantage point from

which they may gain a rational view of pathological processes." It was not intended as a text-book of physiology as a science in its own right, but the steady development through successive editions has left very few corners of this subject untouched. In style it is eminently readable, and the clinical references are sufficient to check the wandering interest of the medical student who craves for some application of his scientific studies.

The new edition has been brought up to date by numerous small revisions or re-arrangements. It is too early to expect the repercussions of the war to influence text-books, so this edition contains none of the newer physiology which has arisen as a result of international emergencies. It may be described as a very faithful representation up to the period 1940–41. The main alteration in this fourth edition is in format rather than in subject-matter. The pages have been divided into two columns and enlarged. The type is reduced in size, as are many of the illustrations and diagrams. The result is a volume which is less bulky to handle, but it is doubtful whether the reading matter is as well presented, and illustrations, never a strong feature of this book, have certainly suffered. Certain tables and diagrams have become displaced from their text, and few of the micro-photos are of any real value.

Despite this adverse comment, which may rest upon some degree of personal conservatism, the book remains a most valued member of the physiologist's library and one that can be safely recommended to all who wish to study physiology in relationship to medicine. W. R. S.

Applied Physiology. By SAMSON WRIGHT, M.D., F.R.C.P. Eighth Edition. Oxford University Press. *Price* 30*s.*

IT is useless for a student to buy a text-book unless he will be able to read it. The fact that Samson Wright's book is readable is partly due to the efforts of the publishers. It is brightly bound, printed on good paper and well set. We wish that all medical publishers could reach this standard of book production. In spite of the book passing into its eighth edition, the author has kept within the reasonable limits of one thousand pages. His style is compact and usually clear. In this edition he has added two hundred new illustrations. These are of real value in illustrating and underlining the points he makes in the text.

Throughout the book emphasis is laid on physiology in disease. The student who has entered the wards will find here the answers to many questions that may occur to him in relating his new clinical knowledge to physiology. He will find this book well up to date, with accounts of experimental hypertension and of hormone therapy, to mention only two important lines of advance.

The preclinical student may find difficulties. He has to sift the normal from the abnormal, realising that his primary aim is to learn something of the scientific approach to problems and to learn, so far as is possible, how the human body works. Further, besides being dogmatic, this book is not wholly reliable. The account of the chloride shift is confusing and, in the section on pain, space is given to the theory of nocifensor nerves in the production of cutaneous hyperalgesia. There is no anatomical evidence for the existence of these nerves and their existence need not be assumed if the postulates of central radiation and central summation of stimuli be accepted. Although this book is of great value to the clinical student, it cannot, perhaps, be wholeheartedly commended for the use of the preclinical student. J. T. W.

Pharmacology. By J. H. GADDUM, Sc.D., M.R.C.S., L.R.C.P. Second Edition. Oxford University Press. *Price* 21*s.*

THIS book is perfectly suited to the needs of students preparing for the M.B. examinations and the publication of a second edition is gratefully welcomed, copies of the first edition having long been unobtainable. Much has been written under the title of Pharmacology which has had little concern with the subject, but Professor Gaddum never digresses into mere pharmacy or materia medica.

In its essence Pharmacology is the science which deals with the response of biological systems to any form of chemical interference. Hitherto it has advanced most rapidly on the biological plane, but as reasearch in biochemistry proceeds it is to be expected that the more fundamental chemical and physical bases of drug action will be elucidated. The subject can be considered systematically from the physico-chemical viewpoint or from that of experimental biology, but the general clinical

picture evoked by a therapeutic substance is a composite one, arising from the direct action of drug on tissue and from the physiological repercussions thus brought into play. It is the ultimate hope of the undergraduate that his studies will help him to read the meaning of this picture and to apply his remedies with understanding. Professor Gaddum devotes most of his book to the *via media* between the fundamentals of biochemistry and the applied pharmacology of the clinician, but gives sufficient information concerning all branches to build up for his readers a well-rounded concept of the whole. His descriptions are lucid, his factual matter carefully selected and the background of experiment is sufficiently indicated to give life to his exposition.

N. M.

A Textbook of the Practice of Medicine. Edited by F. W. Price, M.D., C.M., F.R.C.P., F.R.S.Ed. Seventh Edition. Oxford University Press. *Price* 42*s*.

THE seventh edition of this famous text-book appears five years after its predecessor and twenty-four after the first edition. There have been no major changes in its contents, though a multitude of minor ones, and (a matter for congratulation) there has been no increase in size.

It is impossible to review such a volume as this in detail, and only a few general remarks are possible. Large text-books of this type, written by a number of authors are bound to suffer from unevenness, and " Price " has always seemed to be an outstanding example of this fault. Some of the sections, notably that of the late Sir Arthur Hurst on the gastro-intestinal tract and those devoted to endocrine and psychological disorders, are brilliant and stimulating. Others are regrettably dull, verbose and sometimes frankly out of date, exhaling a faint odour of mothballs and iodoform. One hopes that it is neither irreverent nor irrelevant in this connection to point out that one-third of the contributors to this edition are either " Consulting " or "Emeritus." A transfusion of fresh blood in the next issue might not come amiss.

The absence of illustrations has always seemed a pity, although it is doubtful if the gain from their introduction would be worth the consequent increase in the size of the book. But one feels that perhaps a rather stricter editorial pruning of the more verbose monographs might enable some pictures, say, of some of the tropical diseases or of the less common nervous disorders, to be added without producing undue corpulence.

Nevertheless, " Price " remains the most complete and, on the whole, the most authoritative British text-book of medicine. Despite some faults, it is an indispensable adjunct to any medical library, private or public ; and the young physician faced with a knotty problem will still, if he is wise, continue to " look it up in Price." J. R. F.

Textbook of Medicine. By Various Authors. Edited by J. J. CONYBEARE, M.C., D.M. Oxon., F.R.C.P., Physician to Guy's Hospital, London. Seventh Edition. E. & S. Livingstone, Ltd. *Price* 30*s*.

THE whole-hearted recommendation of this admirable text-book in no way depends on feelings of local pride. In this regard the popularity of the book speaks for itself. Its contributors are widely drawn from many hospitals and this ensures an absence of parochialism. At the same time editing has produced a homogenous volume and one no longer regrets the text-book by a single author, possible and perhaps desirable in the past, difficult to accomplish to-day.

This book is well balanced, factual and practical as well as eminently readable. It is an excellent text-book for the student ; for the general practitioner it is a handy reference book unencumbered with over-elaborate detail.

This, the seventh edition in fifteen years and the fourth since the beginning of 1939, does not differ in general form from its predecessor. Much, however, has been rewritten, especially in the sections dealing with diseases of the chest, the cardio-vascular system and in the section on renal diseases. In addition, the Editor has added a useful short summary on the sulphonamides. The section on psychological medicine, in line with the rest of the book, is especially to be recommended in that it is practical rather than abstruse, and presents difficult material in a readily intelligible form.

Introduction to Diseases of the Chest. By JAMES MAXWELL, M.D., F.R.C.P. Second Edition. Hodder & Stoughton, Ltd. *Price* 12*s.* 6*d.*

THIS book is accurately described by its title. It is a well-written thumb-nail sketch of chest disease, if that term can be applied to a book of 286 printed pages. It has also 66 illustrations, mainly X-ray pictures, which might be, perhaps, better printed. I imagine that it is aimed particularly at the examination candidate and, if that is the case, it is well aimed. E. R. B.

A Manual of Tuberculosis—Clinical and Administrative. By E. ASHWORTH UNDERWOOD, M.D., D.P.H. Third Edition. E. & S. Livingstone, Ltd. *Price* 15*s.*

THIS book is a summary both clinical and administrative of the treatment and diagnosis of tuberculosis in all its forms. It is well illustrated and clearly written. Being a summary, of necessity it tends to over-simplification of the problems involved and it does not deal at any length with prognosis. But it has valuable chapters on the essential administrative side of the tuberculosis problem which is often not dealt with in larger text-books on the disease. The book is designed by its author, not only for medical students and practitioners, but also for nurses and laymen interested in tuberculosis schemes, and it should whet the appetite of the former while satisfying the latter. E. R. B.

A Manual of Psychological Medicine. By A. F. TREDGOLD, F.R.C.P. Second Edition. Balliere, Tindall & Cox. *Price* 18*s.*

DR. TREDGOLD has succeeded in presenting the difficult subject of psychological medicine with a refreshing clearness all too seldom experienced in the works of some present-day authors. In his *Manual of Psychological Medicine*, which has reached its second edition, he stresses the necessity of arranging cases according to their clinical features and describing them from this point of view.

It has long been a mystery why so many modern writers on psychiatry should allow the attention given to the various psychological doctrines, which from time to time hold sway, to overshadow the clinical aspects. Only too often do we realise that one or other author is allowing fallacies of reasoning to creep into his work as he recasts his material to fit in with his own particular school of thought rather than in accordance with the more objective clinical findings.

The author is well aware that psychological medicine is an exceedingly complicated subject, with ramifications in many fields of knowledge and that any attempts at completeness of presentation are foredoomed to failure because of this reason. The subject material is arranged in the orthodox manner, due consideration being given to the mode of working of the normal mind, the nomenclature and classification of mental abnormality, general symptomatology, clinical descriptions of the various syndromes met with in psychiatry, special forms of treatment, the legal aspect and, finally, the sociological factors.

The clinical descriptions are excellent and there is no difficulty in recognising among the patients the behaviour and characteristics that he collects together as disease entities. For this reason alone the book is of great value to the student. If the fact is borne in mind that Dr. Tredgold's main purpose was to provide a reasonably short, plain and practical account of the essentials of this branch of medicine, and that he has drawn his case material from his own personal experience of many years of work in this field, then one can recommend his *Manual of Psychological Medicine* to student and graduate alike, secure in the knowledge that they will find that which is, unfortunately, only too rare in psychiatric literature—namely, a book written on the lines of sound commonsense. A. MACL.

The Treatment of Acute Intestinal Obstruction. By JUDSON T. CHESTERMAN, M.R.C.P., F.R.C.S., F.A.C.S. 1st Edition. J. & A. Churchill, Ltd. *Price* 10*s.* 6*d.*

THIS monograph deals with the pathology induced by intestinal obstruction and by the release of the obstruction, the early diagnosis and principles of treatment of acute obstructive lesions, and the application of these principles to the individual types of intestinal obstruction. It is based upon the author's wide experience in the treatment of surgical emergencies, upon his own experimental work and upon an extensive study of the literature of the subject.

The section in pathology is an adequate summary of the voluminous experimental work which has been carried out on the subject, but it does not clarify the many practical points which are still obscure. The chapter on diagnosis is excellent and stresses the importance of *early* diagnosis in reduction of mortality. The general principles of treatment are soundly expressed and the methods adjuvant to operative treatment receive proper attention, particularly those of fluid balance and suction drainage. The treatment of individual types of intestinal obstruction occupies the last two-thirds of the book and the problems are dealt with in a thoroughly practical manner.

The author has not hesitated to state his own opinions and, in view of his extensive experience, these must carry great weight. The monograph will give food for thought to all practising surgeons, and will be a most useful *vade mecum* to those widely experienced in this aspect of surgery. S. H. W.

A Synopsis of Surgery. By E. W. Hey Groves, M.S., F.R.C.S. Edited by C. P. G. Wakeley, C.B., F.R.S.Ed., F.R.C.S. Twelfth Edition. John Wright & Sons, Ltd. *Price* 25*s*.

THIS book endeavours to cover in its six hundred pages the whole realm of surgical diagnosis and treatment interspersed with snatches of surgical pathology, and with a section on surface anatomy at the end. In doing so it falls between two stools; it is not full enough to be used as a textbook of surgery, nor small enough to be slipped into the pocket for quick revision of the essential features of the commoner conditions. It is simply an *aide-memoire*, written in note form, primarily for the use of those whose own note-taking has been perhaps a little limited. Its text, however, is sound, the salient points clearly noted; and the subject-matter is set out briefly with headings and sub-headings to facilitate rapid revision. A number of diagrams are included, and the section on surface anatomy is well illustrated.

This book is not to be regarded as an easy way of avoiding the more solid-looking standard textbooks. It is a synopsis to be used after the regular use of one of the larger books; and the harassed student rapidly revising for his final examination will find it useful for this purpose. J. E. B.

A Practical Handbook of Midwifery and Gynæcology for Students and Practitioners. By W. F. T. Haultain, O.B.E., F.R.C.P.Ed., F.R.C.S.Ed., F.R.C.O.G., and Clifford Kennedy, F.R.C.S.Ed., F.R.C.O.G. Third Edition. E. & S. Livingstone, Ltd. *Price* 20*s*.

MEDICAL text-books may be divided into three classes—the complete and weighty reference book; the standard and still heavy text-books; and, finally, the concise text-book of particular value to the student during the last few months before an examination. This practical handbook is an outstanding example of the latter class.

The book is written clearly and is very readable despite the inclusion of numerous classifications and tests which, though of infinite value, so often make smooth reading difficult. The sections on obstetrical and gynæcological operations are of an appropriate length and well illustrated. The book is up to date and full use of the sulphonamides is given. There is also a particularly valuable chapter on the use of hormones.

It is a pity that the measurements of the increase in size of the uterus are given in "finger-breadths" above the pubis or umbilicus; whilst the intertuberischial diameter is measured with a ruler. Surely a tape-measure is preferable for the former on account of accuracy, and the "knuckles" for the latter on account of the patient's feelings? The space devoted to pregnancy and tuberculosis is the same as that devoted to pregnancy and malaria; and syphilis heads a long list of the common causes of abortion. The treatment of retained placenta, of importance both to patient and examinee, is very sketchy, and the performance of Crédé's expulsion under an anæsthetic is omitted. Finally, the boiling of all cows' milk before being given to infants is not stressed as other golden rules are.

However, such points are very few, and the book is of obvious service to the student who has read the larger text-books during his obstetrical appointment, and is now only revising for his examination. The tests of causes of the pathology and symptomatology of the subject form valuable skeletons to many examination questions. As always with Messrs. E. & S. Livingstone's books the printing and paper further add to the attractiveness of this most useful book. M. D. W.

Special or Dental Anatomy and Physiology and Dental Histology. Vol. I. By T. W. Widdowson, L.D.S. R.C.S. Eng. Seventh Edition. Staples Press, Ltd. *Price* 42*s.*

THE new edition of this work conforms to the style of previous editions, and is illustrated by a number of excellent photo-micrographs and line drawings. The text covers the whole of the subject-matter needed by a dental student, and has been brought up to date to correspond with modern conceptions of the subject. It is doubtful, however, whether the student will derive benefit from the inclusion of so many controversial views which must have the effect of producing confusion in the mind of the reader. The chapter on the macroscopic appearances of human teeth has been rewritten. It is unfortunate that mis-spellings have eluded the proof-reader, and in places a looseness in description conveys an idea which the author has not intended.

This book will remain the standard modern work on Dental Anatomy in this country, and the publishers are to be congratulated upon the way in which it is presented. F. S. W.

A Pocket Medical Dictionary. Compiled by Lois Oakes, S.R.N., D. N. (Lond. & Leeds). Assisted by T. B. Davie, F.R.C.P. Seventh Edition. E. & S. Livingstone, Ltd. *Price* 4*s.*

FOR its size this little book contains an abundance of useful information. The definitions and explanations are readily understandable and, apart from being a worth-while component of a medical man's equipment, it should prove of interest and value to the man-in-the-street. A new system of pronunciation was introduced in the last edition and is retained in this; it is simple and sound and should satisfy the majority.

The choice of subjects for illustration is haphazard; even the inclusion of illustrations in a book of this size is a doubtful advantage.

In addition to the dictionary of medical terms there is a comprehensive appendix and much useful data is given on a variety of subjects.

The publishers clearly give as much care and attention to the production of a modest work as they do to the most expensive of their creations. R. H. N. L.

The Nurses' Text-Book of Anatomy and Physiology. By A. M. Spencer, M.B., Ch.B. (Bristol), B.Sc. (Wales). First Edition. Faber & Faber, Ltd. *Price* 8*s.* 6*d.*

A USEFUL book to add to the library of a nurses' training school and one containing concise and clear descriptions accompanied by clear and useful diagrams.

The questions at the end of the book should prove a useful means of testing knowledge acquired as they are followed by the appropriate type of answer.

For the student nurse, it is perhaps more useful, after a preliminary outline of cells, tissues and systems of the body, to commence with knowledge of the bony skeleton and joints before proceeding to the other systems in more detail. J. M. J.

Gynæcology A Handbook for Nurses. By Gladys H. Dodds, M.D. (Edin.), F.R.C.S., F.R.C.O.G. First Edition. Faber & Faber, Ltd. *Price* 10*s.* 6*d.*

A VERY clear, concise and interesting book containing all the information a nurse requires to take an intelligent interest in gynæcological work; also as an introduction to her future work in the midwifery field.

The clear and helpful diagrams add considerably to the value of the book, especially those explaining the procedures undertaken in the "repair" operations. I should like to see a copy of this book in every nurses' library. M. B.

A Ward Pocket-Book for the Nurse. By H. M. Gration, S.R.N., S.C.M., D.N. (Lond.). First Edition. Faber & Faber, Ltd. *Price* 3*s.* 6*d.*

WITH a Ward Pocket-Book for the Nurse, Sister Hilda Gration has filled a long felt need in a most able and practical way.

From its plain illustrations and clear arrangement the student nurse should, at a glance, get a graphic picture of the articles and apparatus needed for daily ward

tests and treatments, even though in very occasional instances small details have been omitted.

The author does not intend to explain procedures, but the nurse will learn the method and use of the equipment when she sees the treatments carried out and will then appreciate the clear order in which the requirements are listed—namely, their order of use. She will find this book handy for last-minute revision when preparing for practical examinations.

For a second edition a section on preparation for special X-ray examination would be welcome.

The modest price and handy size will make this little book an invaluable *vade mecum* to the nurse. We wish it every success. M. D.

Sir W. Arbuthnot Lane, Bart., C.B., M.S., F.R.C.S.: His Life and Work. By W. E. Tanner, M.S., F.R.C.S. Bailliere, Tindall & Cox. *Price* 15*s.*

THIS biography is strongly recommended to all Guy's men and women. The author quite rightly places Arbuthnot Lane next to Lister on the scroll of the great British pioneers of surgery; but his monograph, as he modestly terms it, is not confined to mere adulation. It is a generous and critical review of Lane's life and work and the surgical developments of his time. That was the golden age of surgical progress, following introduction of the aseptic technique of which, incidentally, Lane was the foremost exponent.

Above all, Arbuthnot Lane was a master craftsman, a superb technician: the greatest surgeons have ever been engineers at heart. But he was more than this: he was a creative artist and a true genius. He was unscientific, although he provided unlimited material for scientific research by virtue of his imagination. He was a bad teacher in so far as the orthodox instruction of undergraduates is concerned; but he taught by precept and example all those who were capable of appreciating the brilliance of his methods and his views. Great artists and craftsmen are rarely good didactic teachers; nor are the best clinicians. Unfortunately, perhaps, and largely on account of a defective though apparently inevitable examination system, teaching hospitals tend to foster the pedagogue or schoolmaster. As a rule they do not encourage the unlimited development of individual ideas and personalities. Many potential pioneers have been cramped and frustrated, or even broken, by collective criticism however healthy in the main, by conservatism and by that inertia and delay which are inseparable from the committee system of government. But these have been the lesser lights: real genius has generally flourished in the midst of opposition. Moreover, Lane, being an Irishman, rather liked to trail his coat. Nor does this imply that he was not appreciated in his own time. He certainly was: Guy's, on the whole, was intensely proud of him; his admirers and disciples were legion, the more particularly from amongst the great surgeons of America.

His early mechanical bias is admitted and, indeed, most highly respected; his structural observations, concepts and appropriate aphorisms were beyond praise and will withstand the test of time—*e.g.*, "the skeleton is best regarded as the crystallisation of lines of force." Less happily, perhaps, he applied his theories on the mechanics of the rigid bony skeleton to the alimentary tract, failing fully to appreciate that the bowel is a somewhat complicated muscular organ with an intricate nerve supply. But, as the author of the biography pertinently remarks, in those days morbid anatomy was the only handmaiden of medicine and surgery; experimental physiology, pathology and bio-chemistry were yet to come and still have to make that closer union on which alone medicine and surgery can progress on sounder lines.

The storms of debate which arose in connection with Lane's open treatment of fractures, colectomy as a cure for intestinal stasis and alimentary toxæmia, and in connection with the New Health Society which he founded in 1926, have tended to obscure the fact that he blazed the trail in quite other branches of surgery. He advocated and practised the early operative treatment of cleft palate; he was the first surgeon in this country to open the mastoid antrum and the first to establish the one-time routine treatment of empyemata by resection of a portion of the rib. All this and far more is recounted by the author in proper proportion and in a manner that holds the interest of the reader.

There is an excellent bibliography, prepared by Mr. G. A. R. Winston. It is remarkable to be reminded that Lane, who seemed to write so little, actually wrote so many papers in his lifetime.

The selection of Willie Tanner to compile a biography of Willie Lane has been a most happy choice. Himself a surgeon of outstanding ability, he is fully aware of the genius of the Master. The complementary nature of their characters has enabled him to temper his manifest appreciation with a balanced judgment which lends dignity, charm and the stamp of truth to the whole work. F. C.

Lewis's, 1844–1944. H. K. Lewis & Co., Ltd. Free on application.

THE completion of a century's work is an event which may always be looked upon with justifiable pride—especially when the work has been work well done. Lewis's celebrated their centenary in 1944 and, even if the event may have passed by quietly and without fuss, medical men are nevertheless grateful to this famous publishing house for their manifold contributions to the literature and progress of medicine.

This attractive volume gives us "a brief account of a century's work." It may be brief, but it is certainly full enough to be interesting. It tells the story of the growth of this firm from humble beginnings to the flourishing concern we know to-day. There are many anecdotes, together with several sidelights on well-known personalities and on the origin of books that have now become firmly established; one chapter is devoted to the Lending Library with which so large a proportion of students are, or have been, familiar.

The good wishes of the medical profession will accompany Lewis's through their second century. R. H. N. L.

Sport

The Blues' Committee

At a recent meeting of the Blues Committee the following Blues were elected :—

Rugby Football Club.—Blue : P. J. Dwyer ; C. H. Kinder ; A. G. MacCallum. Half-Blue : A. J. De Villiers ; B. Ecksteen ; M. Hatton ; J. B. Keeling ; D. Le Clus ; F. J. Van der Westhuizen ; T. K. Walker.

Association Football Club.—Blue : I. L. Busbridge ; R. A. C. Dove ; H. R. C. Riches ; A. E. Trist. Half-Blue : R. K. Foster ; J. C. Leckie ; E. M. Newton.

Athletic Club.—Half-Blue : H. A. H. Ohlrich.

Hockey Club.—Blue : K. Bolt. Half-Blue : A. E. Doyle ; J. B. Harris ; I. Kelsey Fry ; K. Y. Khong.

Boat Club.—Blue : D. Brett ; J. A. Bulleid ; T. H. S. Burns ; J. H. Inskip. Half-Blue : A. A. W. Fooks.

Squash Club.—Half-Blue : J. E. E. Attale ; L. D. Carton-Kelly ; L. Jacobs.

L. D. CARTON-KELLY,
Hon. Sec., Blues Committee.

Rugby

GUY'S *v.* LONDON IRISH.

(*At H.O.P., Saturday, April 6th*, 1946.)

Result : Guy's, 3 points ; London Irish, 20 points.

In their last match of the season Guy's were decisively defeated by London Irish by 2 goals, a dropped goal, a penalty goal and a try to a penalty goal. This was probably one of the worst games Guy's have played this season, and it was most disappointing to an enthusiastic crowd of supporters to witness such a poor display so entirely lacking in team work. Never at any time during the game were the forwards able to stop the lively Irish pack swooping down and creating havoc amongst our backs, who had no chance of going down on the ball against those determined loose rushes.

Guy's had quite a lot of the ball from the set scrums and occasionally in the loose, but the backs were quite unable to make any progress owing to keen marking by their opponents, and their own inability to introduce any manœuvre which might have led to a score. Consequently most of the movements ended on the wings. At full-back Lewis played a capital game, and Bailey, at scrum-half, was most plucky considering that the opposing forwards found it comparatively easy to smother many attempts of his to pass out, owing to the lack of "shove" from the Guy's pack. It appeared that the only forwards making any attempt to play as forwards were the two second row men, MacCallum and Hilliam ; the remainder were far too anxious to play loose, and this presented J. Tynan, at stand-off half for London Irish, with numerous chances to break through of which, he took full advantage.

The game started with a tremendous rush by the Irish pack, and at the first check two of their forwards were receiving attention on the touchline for facial injuries. On the resumption N. Beattie neatly dropped a goal to give them the lead, and they went further ahead when J. Tynan broke through to send W. V. Lane in for an unconverted try, but Lewis reduced the lead with a penalty goal.

London Irish were complete masters in the second half and scored an early try through R. A. Steele, which was converted by R. Pedlow. Guy's had a few attacking movements and the nearest they came to scoring was when D. Le Clus was forced into

touch; his brother, F. Le Clus, knocked on when well placed, with almost a clear field, and Van der Westhuizen went wide with a long drop-kick. Faulty tackling allowed Lowry to run through to send W. Lane over for a try, which R. Pedlow easily converted, and the latter kicked a penalty goal near the end.

All Guy's followers must have heaved a sigh of relief when the final whistle blew, especially as a better display was expected from a side that had its full cup team with two exceptions.

Rowing

THE HEAD OF THE RIVER RACE.

The head of the river race was held once again under peace-time conditions on Saturday, March 30th, 1946. The course was from Barnes Bridge to Putney Bridge, a distance of three and a half miles, and, in all, seventy-one crews entered. The weather conditions were ideal, and a large crowd turned out to watch the eights being marshalled between Barnes and Chiswick bridges.

The Guy's crew started in their 1939 position at 37th. They were somewhat disheartened by the absence of their captain, T. H. S. Burns, who was taking an examination in Oxford, but they took the boat off in lively fashion, and maintained a long, firm stroke up to Hammersmith Bridge. Here it was found that they were rapidly overtaking the boat ahead. A few "tens" brought about the desired result, and the crew settled down to the second half of the course in great heart. Just past Fulham football ground the bellowings of the cox told the crew that a second eight was looming ahead, and a final effort thrust the Guy's boat past it just as the finishing post was reached. As crews were started off at ten-second intervals this was very encouraging.

The results, declared later in the day, showed that Guy's had come seventeenth out of 71, thus rising 20 places. Since time for training is, of necessity, limited, and crews from the Univeristies with whom we were competing practise four times a week, and were freshly trained from the Lents and Torpids, this was a very creditable performance.

The Crew.—Bow, W. Williams; 2, J. H. Inskip; 3, A. F. Crick; 4, J. A. Bulleid; 5, E. F. Soothill; 6, W. van't Hoff; 7, D. Brett; stroke, R. T. Lowein; cox, A. A. W. Fooks.

At a recent meeting of the Boat Club, D. Brett was elected Secretary.

It was announced that a race had been arranged with St. Thomas's Hospital to take place shortly. Also it appears to be possible to enter both an eight and a light four for the Henley Regatta in July.

Hospital Information, etc.

Pass List

UNIVERSITY OF OXFORD.

2nd B.M. EXAMINATIONS.

Hilary Term, 1946.

Forensic Medicine and Public Health.

M. G. D. Davys — E. L. Magee
R. E. A. Hansen — D. M. Strange
T. A. Madden

Special and Clinical Pathology.

T. H. S. Burns — T. A. Madden
M. G. D. Davys

Papers by Guy's Men

Oliver Lyth. Some medical experiences in South-West China. *Med. Press*, 1946, **215**, 238.

Marre, I. R. Scratch patterns as an aid to diagnosis in three common skin conditions. *Ibid.*, 244.

Sir Heanege Ogilvie. Place of medical societies in the Doctor's life. *Lancet*, 1946, i, 525.

Rogerson, C. H., and Others. A gag for use during electric convulsion therapy. *Brit. Med. J.*, 1946, i, 611.

Galloway, W. D. Functional uterine bleeding. *Medical World*, 1946, **64**, 263.

Waterfield, R. L. Sternal-puncture needle. *Lancet*, 1946, i, 576.

Change of Address

G. E. Baxter, Capt. A.D. Corps, 84th Army Dental Centre, Bodmin, Cornwall.

W. Hughes, M.R.C.S., L.D.S., 30, Station Road, Orpington, Kent. (Tel.: Orpington 1223.)

The Services

CASUALTY.

Wounded.

Capt. D. R. I. Mason, R.A.M.C.

Mentioned in Dispatches.

Lt.-Col. M. J. Lindsey, R.A.M.C.; Major R. Glanvill, R.A.M.C.; Major C. R. Morgan, R.A.M.C.; Capt. W. M. Smith, R.A.M.C.; Capt. J. R. Trounce, R.A.M.C.

Births

BLAZEBY.—On April 16th, 1946, at Guildford, to Maryl (née Crutchley), wife of Dr. Henry Blazely, of Lasham Lea, Witley, Surrey—a son.

HIND.—On April 4th, 1946, at Guy's Hospital, to Margaret (née Fearnehough), wife of A. W. Hind, Capt. R.A.M.C.—a daughter (stillborn).

SANTON.—On March 18th, 1946, at Taneatua, Bay of Plenty, New Zealand, to Phyllis Mary Santon (née Lloyd)—a daughter.

Deaths

BENT.—On April 12th, 1946, suddenly, at Sunnyside, Lingfield, Percy C. V. Bent, M.R.C.S., L.R.C.P.

JEWELL.—On April 1st, 1946, at Marmora, 207, High Road, Balham, John William Frank Jewell, M.D., M.S. (Lond.), dearly loved husband of Marion Jewell.

THORPE.—On April 10th, 1946, at 7, Woodcote Valley Road, Purley, William George Thorpe, M.R.C.S., L.R.C.P., M.D., aged eighty years, late Balham High Road, S.W.17.

EDS. { J.M.H. / R.H.N.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

TO obtain a House Appointment is an achievement of great value to the newly-qualified doctor. It is the logical stepping-stone between the freedom of unqualified study and responsibility of private practice or specialty; it is the means whereby knowledge—much of which is academic and theoretical—becomes converted into valuable practical experience. A consideration therefore of the present state of affairs with regard to these appointments is of obvious importance.

An increasing number of House Appointments are now being given to Ex-Service men. The last two lists of House Officers (those of the periods February–April and May–July) show that between forty and fifty per cent. of these jobs have been given to those who have recently left the Forces. The natural student reaction to this is to speculate on the question of whether this increase is likely to continue, and, if so, to what extent. A great many newly qualified men, who would otherwise have had house jobs, are now missing their chance of gaining this valuable stepping-stone before they enter the Forces. It may well be argued that this state of affairs will right itself in time because the newly qualified men of to-day are the Ex-Service men of to-morrow; in this connection, however, it is important to note that a great many, if not all, of those from the Services now getting jobs did have house appointments—either at Guy's or elsewhere—before they joined the Forces. Hence these men are having the benefit of appointments before and after their duty in the Services, while many recently qualified men miss their chance of a job now without, it seems, even the promise of one when they return to civilian life. Finally, the present arrangement allows of appointment lasting six months automatically for the Ex-Service man and only half that period automatically for the man of more recent qualification.

All these considerations are, of course, no reflection whatever on the Ex-Service men and no one will seek to deny such men the opportunity for as much mental rehabilitation as possible; they do, however, demonstrate the need for a statement of policy with regard to the future. Is the percentage of appointments for Ex-Service men to continue increasing? Is there to be any guarantee that those missing jobs at present, on account of the new system, will be compensated by receiving appointment after their spell of duty in uniform?

If the preceding remarks appear to constitute entirely destructive criticism, then we would offer the following constructive suggestions. Many of the present difficulties might be solved by the introduction, for Ex-Service men, of some type of refresher course such as can be taken by the civilian practitioner. This would include attendance at the Out-patients' Department and ward rounds, and might reasonably be supplemented by short courses of lectures on recent developments in such branches of study as pathology and therapeutics. Such a course might well be of more value to the Ex-Service man. It would leave available a greater number of house appointments for the man fresh from qualification who is more fully equipped to undertake them both as regards his state of knowledge and his relationship with the contemporary medical surgical and nursing staff—there being virtually no break between student days and the period as house-officer.

Complaints regarding the greater length of automatic appointment for Ex-Service men might be countered by the reinstitution of six-monthly appointments as a routine. The recent reversion to the pre-war interval of six months between the M.B. examinations would counteract the smaller number of jobs per year thereby made available. Finally, appointment for this greater period permits the development between house-officer and ward sister of a greater degree of co-operation which must inevitably lead to better results in the long run.

WE have pleasure in publishing elsewhere in this issue tributes to Miss McManus on her retirement and would like to add here our very best wishes to her for the future

WE take this opportunity of extending a very hearty welcome to Miss Dorothy M. Smith, our new Matron, who has recently returned to Guy's from the Middlesex Hospital.

Obituary

JOHN E. HUMPHERY.

MR. JOHN E. HUMPHERY became a Governor of Guy's Hospital in 1917 and he took an active and ever-increasing interest in its welfare. Throughout the whole of his association with the Hospital he was a regular attender at the weekly meetings of the House Committee and his advice and help were frequently sought and always willingly given. His quick brain, his disregard for anything but essentials and his willingness to make decisions and to undertake responsibilities—both invariably justified by the ultimate outcome—gave him a position of great influence on the Court of Governors, despite his inherent reluctance to appear in the limelight. On the outbreak of war in September, 1939, when the Chairman of the Court was recalled to the Royal Air Force, Mr. Humphery was elected Chairman and, later, 1944, Treasurer of the Hospital.

He devoted himself heart and soul to the work and his keen and energetic personality provided a constant source of inspiration and encouragement to the staff. He was quick to perceive the desirability of keeping in close touch with the Medical Staff and always lent a willing and sympathetic ear to their views. As a result the Medical Staff have been kept *au fait* with Hospital business and have been constantly consulted with regard to plans for the future. He was always capable of taking the long view and, being fully convinced that a Teaching Hospital of the size and importance of Guy's should provide a minimum of 1,000 beds on the site, he had made that his aim, although he knew that he had little prospect of living to see it attained. He saw the Hospital through a very difficult and trying time, and in doing so he won the admiration, loyalty and affection of all at Guy's.

Mr. Humphery had many business interests in London. He had been a Managing Director of Hay's Wharf for many years, he was the Chairman of the Court of Directors of the Royal Exchange Assurance, and he held many directorships. A prominent member of the Clothworkers Company, he was Master in 1937 and, in this connection, the degree of LL.D. was conferred on him by the University of Leeds.

When the Goodenough Committee was set up to enquire into the position of the Medical Schools of the country, Mr. Humphery at once realised the necessity for the establishment of a body that could speak authoritatively for the Teaching Hospitals concerned, and through his initiative the British Teaching Hospitals Association came into being. Elected Chairman of the Association he did not spare himself and his work in this connection, added to his other commitments, undoubtedly precipitated his final illness.

His death deprives the Hospital of an old friend and a wise and valued counsellor at a time when he could ill be spared.

Malaria in Soldiers Returned from Abroad

By IAN McCALLUM, M.B., M.R.C.P.

DURING the War there have apparently been few cases of malaria dealt with at Guy's itself (1), in contrast to the frequency with which the sector hospitals encountered malarial relapses in soldiers or ex-soldiers who had returned to this country from the Middle and Far East. This is explained by the proximity of some sector hospitals to military centres where men from these areas were gathered shortly after their return. During one period at least, in one hospital in Sector 10, it was unusual not to have several soldiers in the wards in various stages of recovery from a malarial attack, with frequent admissions to replace those discharged. The great majority of these relapses were of the benign tertian variety (P. vivax) and there were relatively very few due to Plasmodium Falciparum (Malignant Tertian). A brief account follows of experience with about seventy cases of malaria in men returned from the Middle East, Sicily, Italy and Burma who relapsed in this country, and of problems that arose in connection with them. In particular the possibility of a local epidemic due to their presence in a suitable part of England is considered. They were all seen and treated in E.M.S. Hospitals in Sector 10, one group of forty-nine men being at Joyce Green Hospital, Dartford.

All the cases seen were admitted to hospital between March, 1944, and May, 1945, and, with one or two exceptions (such as men discharged from the Army for other reasons) they were fit men on active service ; their average age was twenty-nine years. In most of them a clinical diagnosis had been made before admission and, in some cases latterly, this had been confirmed microscopically. Admissions tended to be in groups of two or three at a time, often corresponding with a spell of cold weather. The earliest groups had returned to England in November, 1943 ; they, together with others who returned three or four months later, had come from North Africa. Men who had been in Sicily were followed closely by those who had been in Sicily and Italy, while the last groups were practically all from India and Burma. Amongst all these there were only two infections due to P. Falciparum, one of them a mixed infection with P. Vivax. Clinically they were no different from the others and no pernicious forms of malaria were met with. Between May and August, 1944, a number of men were admitted to hospital who had returned from Sicily in February and March that year. Most of them had had three or four relapses in that time, for some of which they had been given treatment. Relapses did not commonly occur, however, until they had been in this country for three or four weeks, probably due to the mepacrine they were usually given on disembarkation.

PREVIOUS ATTACKS.

Patients often denied having had any previous attack of malaria before returning to this country although, on close questioning, some would admit to slight shivering attacks at times, which had not been severe enough for them to report sick. In a series of fifty patients who were closely interrogated on this point, thirteen would not admit to any symptoms before their return to England, although they had been for some time in areas where infection was rife. Malarial infection usually declares itself in a week or ten days after the individual has been bitten by an infected mosquito although sometimes the incubation period may be much longer. (2) In these cases prolongation of the incubation period was undoubtedly due to the taking of prophylactic mepacrine while in the malarious area and the suppression of the infection until the mepacrine was stopped in this country.

Regular prophylactic mepacrine was issued to troops with the object of suppressing attacks and was often taken for three weeks before entering a malarious district and continued for a month after leaving it. Patients were therefore asked the amount of mepacrine they had taken and the regularity with which they had taken it, but the men were often vague and uncertain on these points. In those from Sicily and Italy prophylaxis appeared to have been irregular, perhaps due to the nature of the invasion operations and difficulties in supply and supervision. Most of them, however, had been given mepacrine regularly while on board ship on the way home and a month's supply on disembarkation.

SYMPTOMS.

As the majority presented with typical symptoms there was usually little difficulty in diagnosis if the possibility of malaria indicated by the history was borne in mind. Shivering, pain in the back and limbs and headache, often frontal were the commonest complaints and often of definite tertian periodicity. No cases of quartan malaria were seen. In some men these symptoms were preceded by one or two weeks of malaise with occasional feverish bouts. Abdominal pain was a common complaint and was usually described as of a dull aching character and was referred to the left subcostal region. Vomiting was also common and occurred before the administration of quinine. It was not severe in any of these cases and in none of them was it necessary to give parenteral fluids. The attacks began in the morning or early afternoon and the patient would usually be admitted the same evening.

The appearance of a flushed and languid man drenched with a heavy sweat was characteristic on admission—the end of the hot stage. Temperature at this time varied from 99° F. to 104° F. and fell to normal by the following day. Herpes labialis often appeared within a few days. Jaundice was seen in only two cases and was then slight; it did not seem to be related to the hæmoglobin per cent. in these men. The spleen was palpable in nearly half the cases at the time of admission and was often tender. In others, where the spleen could not at first be definitely felt, there was sometimes tenderness under the left costal margin and the spleen became palpable in the next day or two.

DIAGNOSIS.

Having made a probable diagnosis on the above symptoms and signs, confirmation was sought by the microscopical examination of a blood smear taken at the time of examination. This was stained for about twenty minutes with Leishman's stain and examined for up to twenty minutes for malarial parasites which were often very scanty. A high proportion of monocytes in the smear was regarded as suggestive and a stimulant to further search. Sometimes smears taken on successive days were necessary. Where no parasites could be found at first there was sometimes difficulty in making a final diagnosis, particularly if there was a set of symptoms which suggested at first some other condition. That malaria could easily be missed was suggested by one man sent in as a possible appendicitis with vomiting and some abdominal pain. Although both malaria and appendicitis might have been present, the history and signs suggested the former only and the parasites were found in his blood. Another man had received treatment for "acute bronchitis" three weeks previous to admission, for what was on retrospect clearly a relapse accompanied by a mild bronchitis, as was indeed a common combination. Again there was no difficulty in making a positive diagnosis on examination of a blood smear.

In one particular instance there was great uncertainty about the diagnosis at first; this was a primary attack of benign tertian malaria in a man of thirty-five years. He had returned home from Sicily where he had had no symptoms whatever, and had been taking mepacrine regularly. He was admitted complaining of frontal headache, pain in the back and abdomen, shivering and sweating. He had had an ordinary cold for about a week previously. On examination he was hot and sweating with a temperature of 100° F. and his spleen could not be felt. No signs were found and he was thought to be probably suffering from malaria. No parasites were found in a blood smear, however, after a long search. For the next three or four days he ran a temperature of 100–102° F. without remission, with vomiting and diffuse abdominal tenderness, and later diarrhœa. His pulse rate remained fairly stationary at 70–80 per minute for the first three days and then gradually rose. Investigation of blood agglutination reactions, fæces, and urine all drew a blank, and further blood smears were also negative. A blood count showed 4,600 leucocytes, of which 19 per cent. were monocytes. It was only on the fourth day after admission that scanty parasites of benign tertian malaria were found.

TREATMENT.

Once the diagnosis had been confirmed microscopically a course of treatment on the lines recommended by the War Office pamphlet on the subject (3) was started. Ten grains of quinine hydrochloride were given three times a day for two days, followed by 0.1 gramme of mepacrine three times a day for five days. After two days' interval pamaquin was given in does of 0.01 gramme three times a day for five days, the whole

course taking about a fortnight to complete. This was combined with plenty of fluids and a light diet, with sodium sulphate as required.

Recovery was uneventful following this treatment apart from an occasional rise of temperature on the second day after admission, presumably due to non-absorption of quinine. In a week or ten days the spleen became impalpable in practically all the patients with the exception of one or two in whom some enlargement persisted at time of discharge. Sometimes headache, controlled by aspirin, or a left-sided abdominal discomfort persisted for a few days, but there were no toxic effects directly attributable to the drugs used in treatment. The patients were allowed up towards the end of their mepacrine course, but were kept in bed during the course of pamaquin, as recommended. (3)

Hæmoglobin estimations were done as a routine on admission and before discharge, if necessary. Most men had a value of 80–90 per cent. Hb., the lowest recorded being one of 29 per cent. in a patient from Burma. All responded well to ferrous sulphate by mouth, but in a number of cases convalescence was delayed on this account. As the course of treatment took fourteen days to complete, it was possible to discharge a patient back to his unit between seventeen and twenty-one days after admission. This was important, as most men were anxious to get back to their original unit which they were unlikely to do if detained for over three weeks.

The effectiveness of treatment was very difficult to judge, as once it had been completed the patient disappeared completely from one's ken. It is impossiblt to say what proportion of them subsequently relapsed and how soon this occurred as none were re-admitted to the same hospital, to my knowledge. It is likely, however, that the rate of further relapses was high, judging from the histories of some of those treated. One man, for example, was admitted nine days after having completed treatment on similar lines elsewhere, with a typical attack of malaria and "signet rings" easily found in his blood. Another gave a history of seventeen relapses, fourteen of which had occurred in the last twelve months. As far as one could tell he had received adequate treatment on a number of occasions. Yet another man was retained in hospital after his course had been completed as he developed symptoms of gastric ulcer; he relapsed within in six weeks while still in the ward.

It seems, therefore, that although this course of treatment was described as "found to be the best in the alleviation of symptoms and in prevention of relapse" (3) it is still far from satisfactory. Perhaps paludrine will prove to be more effective in dealing with the problem.

THE POSSIBILITY OF INDIGENOUS MALARIA.

The majority of these patients were under treatment at Joyce Green E.M.S. Hospital, Dartford, and an important point in connection with their presence there was raised by Dr. M. Mitman, the Medical Superintendent. This was the possibility of a local epidemic of malaria due to the presence of a number of carriers in the district, particularly as it was low-lying and there were many mosquitos. Such epidemics occurred after the first World War, and it was in areas such as this that the majority of cases were found.

In this part of England and elsewhere in the south-east up to the latter part of the nineteenth century malaria was an endemic disease and common (4). The hospital stands in the midst of extensive marshlands, the Dartford marshes, while, to the east and west, are other large tracts of marshland with their draining ditches and dykes. The Dartford marshes alone comprise over 4,000 acres under the local authority, drained by private and common sewer ditches through sluice gates into the Thames. That these provided suitable breeding grounds for mosquitos was well known by the staff and patients of the hospitals situated on the marshes, as regularly during the summer months they have been bitten every night, often several times, with much loss of sleep.

It was therefore inevitable that many or all of our malarial relapses admitted during the summer months would be bitten by mosquitos, and that, given a suitable carrier and conditions, an epidemic of malaria might easily begin in the neighbourhood.

It is interesting to recall the situation that arose after the war of 1914–18, when men began to return to this country from heavily malarious areas in the Middle East and India. A large number relapsed on return to this country, and, as a result, between 1917 and 1926, there were over six hundred cases of malaria contracted in this

country by people who had never been abroad (5). This was practically all benign tertian malaria as the malignant tertian variety does not persist long in this climate. It was significant that indigenous infection occurred mainly in areas practically identical with those in which true endemic malaria had previously been rife. Obviously conditions there were favourable for the existence of malaria and, indeed, there was evidence that it had never quite been eradicated (6).

The incidence and distribution of malaria are influenced by the temperature and humidity of the district (7). In England the latter is always favourable, but a mean temperature of over 60° F. is necessary for malaria to exist (4). This means that the most favourable months in England are July and August. During these two months, in 1944, nineteen cases of malaria were admitted to Joyce Green who might have been bitten by mosquitos and, as at any one time there were one or two capable of transmitting the disease, this might well have been the start of indigenous infections.

It was necessary to show the presence in or near the hospital of an anopheline capable of transmitting the infection for then all the necessary factors which might lead to the occurrence of cases in the locality would be present. Those cases which were recorded after the first World War were mainly in areas in which *Anopheles maculipennis* is found, and the variety *atroparvus* has a close association with man and is commonly found in houses. From a map published in 1918 showing the distribution of anopheline mosquitos in England and Wales (5) it is seen that they were found to be present in Woolwich, Erith and Bexley Heath to the west of the Dartford marshes, and at Gravesend to the east.

In June, 1944, a mosquito survey in the neighbourhood of Joyce Green Hospital was carried out by Mr. P. G. Shute, of the Ministry of Health, (9). Cow-sheds and stables were inspected in addition to drainage ditches. A number of adult mosquitos, of which there were many to be seen under the roofs of the outbuildings, were collected in test-tubes for further identification. Not many larvæ were seen in the ditches, and it was thought that they were thinly distributed over the marshes which provided an extensive breeding ground for the numerous adult anophelines. In the report submitted anti-larval measures were not advised owing to the extent of the ditches, but, as some of these were in bad repair, it was recommended that they should be cleared and one unnecessary loop filled in. The latter incidentally provided excellent protection for the surveying party when a flying-bomb fell a short distance away during their tour.

Pyrethrum spraying of sheds and stables to attack the adult mosquitos was advised, to be done every two or three weeks until the end of September. The use of mosquito-nets for the patients and a dose of 0.02 gramme of pamaquin as soon as possible after their admission were suggested. The pamaquin would have the effect of sterilising the gametocytes and rendering the patient non-infective if bitten by a mosquito. This measure was adopted immediately, but it was some time before proper mosquito-nets could be procured. At this time also D.D.T. was not generally available in sufficient quantity for it to be used in the wards.

While these precautions were taken at Joyce Green it is doubtful if by themselves they counted for much as, with the danger of a local epidemic not appreciated by others treating the large number of relapsing cases there must have been in this part of England, the possibility of endemic cases was great, given suitable conditions. Nevertheless, as far as one could ascertain towards the end of 1944, no cases of indigenous malaria had been reported in the Dartford district. There is yet no indication that the epidemics which at the end and after the 1914–1918 war were so striking, are going to repeat themselves.

I am indebted to Dr. M. Mitman for permission to quote from Mr. Shute's Report on the Mosquito Survey at Joyce Green.

REFERENCES.

(1) A. B. S. and P.R.A.M. "Malaria at Guy's." *Guy's Hosp. Gaz.* (1945), lix, 491, 221.
(2) "Manson's Tropical Diseases." Ed. Manson-Bahr, P. H. 12th Edn. Cassell & Co., Ltd. 1945.
(3) "Notes on the Treatment of Malaria occurring in Individuals returning from Service in Malarious Areas," 1944. H.M. Stationery Office.
(4) James, S. P. (1926). *Trans. Roy. Soc. Trop. Med. & Hyg.*, 20 : 143.
(5) Shute, P. G. (1944) *J. Roy. San. Inst.*, lxiv, 2, 85.
(6) James, S. P. "Malaria at Home and Abroad." John Bale, Sons & Danielsson, Ltd. 1920.
(7) Gill, C. A. (1921) *J. Hygiene.* 19 : 320.
(8) Hackett, L. W. "Malaria in Europe." Oxford University Press. 1937.
(9) Shute, P. G. Report on Mosquito Survey at Joyce Green, June, 1944.

Miss Emily E. P. MacManus, O.B.E.

MATRON, 1927–1946.

WITH the retirement of Miss MacManus from the Matronship of our Hospital an era comes to an end. Since her childhood, much of which was spent with her uncle in the Medical Superintendent's House, she has been more closely associated with Guy's in all its aspects than any other member of the medical or nursing staffs. She has literally grown up in and with the Hospital, and in a very real sense is part of it. She has made close and human contact with all sections of the Hospital community and many members in all grades can truly call her 'their friend. Her words of encouragement and appreciation to the domestic staff at their Christmas parties, "The Hospital could not go on without you," speak for themselves. In addition to her knowledge of the personnel, there is no part of these vast and complicated buildings of which she does not know the history, details of construction and equipment.

During her matronship of Guy's many important developments have taken place within the Hospital. The new Out-patient Department and Welfare Centre, Nuffield House, the new Children's Wards, the Revelstoke Memorial, the Nuffield Nurses' Home and the York Clinic have become part of Guy's. In the planning, administration and equipping of the new departments Miss MacManus' inspiration and experience have been invaluable to the Governors. She has always kept in mind the primary purpose of the Hospital, the care and comfort of the sick and has fought consistently to have buildings and equipment best suited to this purpose. Expediency and the easy way have never been her first consideration and to obtain the best service for the patients she has spared neither herself nor others. Her knowledge of detail is phenomenal. We older members of the Nursing Staff, looking back, realise the power of her personality and how much we depended upon her ideas and judgment. The ideas were always fresh and original and however breathless one became in their execution, they eventually materialised.

Before Miss MacManus entered the nursing profession she had the advantage of a liberal education and her culture and the wideness of her interests provide the clue to the success and rich quality of her work.

She became a Probationer at Guy's in 1908 and no doubt her toughness and ability for hard work carried her cheerfully through those strenuous years. After this she qualified as a midwife at the East End Mothers' Home. Subsequently she held posts as follows :— Sister at the Kasr-el-Aini Hospital, Cairo, Private Nurse in Egypt and Sister at King's Lynn Hospital. Before the first World War she returned to Guy's as Sister Astley Cooper, where she had wide scope for her talent, not only as a nurse, but as an administrator. It needs no flight of imagination to appreciate with what love and understanding she exercised her authority. As would be expected Miss MacManus volunteered for service in the Q.A.I.M.N.S.R. and was in France from 1915–1918; there she earned her ribbon at the Battle of the Mons, and decorations for service with the British and Allied armies. Twice she was mentioned in dispatches and in 1930 she was invested with the Order of the British Empire. In 1919 the Assistant Matronship of Guy's was offered to her and it was during the three years that she held this post that she began to be a power in the Hospital. Many instances could be quoted illustrating the rather unique and, for those times, somewhat advanced type of administration. Perhaps one could describe it as a combination of strict professional discipline with a rare understanding of individual difficulties of temperament, background and ability. Many a nurse's career has been saved from disaster through a long and patient interview when problems were thrashed out and solved. Time never mattered on these occasions.

Miss MacManus' next venture was something quite different. She became Assistant to the Medical Research Council in carrying out food experiments at Dr. Barnardo's Boys' Garden City in 1922. In 1923 she was appointed Matron of the Bristol Royal Infirmary and this post she held until she became Matron of Guy's in 1927.

From now onwards Miss MacManus was called upon to take an increasingly active part in nursing affairs. Her acute brain, eloquence and fighting spirit were sought for and made use of, on numerous committees dealing with all aspects of women's work. Foremost amongst these are :—The Royal College of Nursing, of which she was a founder member; a member of the Council for a number of years and President from

1942–1944; the General Nursing Council; the voluntary advisory nursing Board for H.M. Prisons (of which she was Chairman); Council of the Queen's District Nursing Association, and of the Overseas Nursing Association; the National Council of Nurses; and the Horder Reconstruction Committee (of which she is Vice-Chairman). In addition, she has served on many other committees dealing with the academic side of the nursing profession. Her knowledge of nursing education is second to none and it is true to say that in all her committee work she has a genius for making the right contacts with leaders in other professions, recognising the value of expert advice applied to nursing problems.

During the last seven years, without losing touch with her work at Guy's and with the above committees, Miss MacManus has carried out an almost superhuman task as Matron of Sector X in the Emergency Hospital Scheme for London. Everything became subsidiary to the war effort and her advice and help were ever ready for the Matrons in the hospitals, with their ever-changing conditions, in this much blitzed sector. This was not easy nor popular work, for with the increasing demands for nurses she often had to rob Peter to pay Paul, but few people asked for help in vain. This work was not all done at the end of a telephone and she travelled literally thousands of miles in her car, often under terrible war-time conditions, for she believed in the great value of personal contact. How eagerly her visits were looked forward to by the Guy's sisters and nurses in the sector and with what patience she listened to their many wants and difficulties. She fought with as much zest for comforts and conveniencies for nurses as she fought on matters of principle with the hierarchy concerned. With all this she was often at Guy's during the worst nights of the blitz, where she slept next to the crypt containing the tomb of Thomas Guy, but whenever there was an incident she was up and helping in the casualty department. Watching her one was reminded of the Arabic answer to the nurses' greeting, "How are you?" "All the better for your presence, ma'am."

This account of Miss MacManus' career must include the principles for which she has worked regarding the nurses' training. For many years she has advocated the Block System of training and instituted a modified form of this fifteen years ago. The balance between theory and practice has never been lost, and her knowledge and interest in the nurses' work in the wards and departments is outstanding. With all her administrative duties she kept abreast of advances in medical science as affecting practical nursing. She will always uphold the case assignment method of training in the wards, believing that this inculcates in the nurse a sense of responsibility from the earliest days of her training. This is consistent with the theory held throughout her administration, of giving scope to the individual. Over-centralisation is anathema to her. From the junior probationer to the heads of departments she gave them their responsibilities and, at the same time, inspired each one with the confidence which she felt in her capacity. Few nurses will forget their interview with Matron when being awarded "stripes" or "strings." In dealing with domestic crises in the Hospital Miss MacManus had an almost Machiavellian touch. Deputations arriving with impracticable demands and scrubbers almost at fighting pitch found themselves drinking tea and shaking hands under her pacific influence.

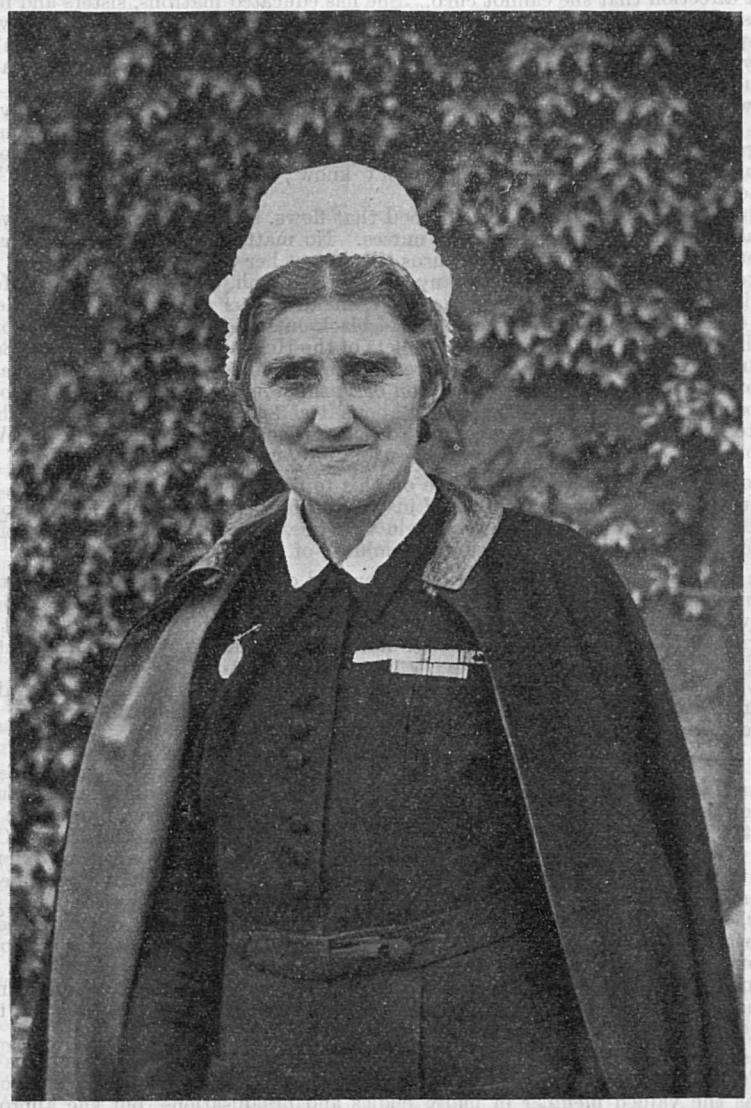
Mention should be made of Miss MacManus' success in her recent broadcasts. She speaks so happily and naturally about our work and manages to convey over the air that sense of service to the community of which she is the embodiment. Her gift as a writer is widely recognised; she has two books on professional subjects to her credit, "Hospital Administration for Women," and, in conjunction with Mr. Mitchiner, Surgeon of St. Thomas' Hospital, "Nursing in Time of War." Her Christmas letter each year has been eagerly read by thousands of Guy's nurses all over the world. Not so well known except amongst her friends is her skill in writing charming little poems.

There is no doubt that Miss MacManus is one of the greatest matrons and women of our age, and those of us who have been privileged to work with her cannot express adequately our love and admiration for her. At times she has demanded of her staff almost impossible efforts. She believed with Browning, "A man's aim should exceed his grasp or what's a Heaven for?" and who could say that our confidence and capacity in ourselves have not increased by the tasks she set us.

One would not expect a woman of such genius and strong personality to make life smooth and easy for those around her, but there is no shadow of doubt that even her critics and the many with whom she has crossed swords on matters of principle will acknowledge her greatness. The Sisters say good-bye sadly and with much affection.

EXTRACT FROM PROFESSOR JOHNSTON'S ADDRESS AT THE NURSES' LEAGUE MEETING, APRIL 26th, 1946.

"So much for Guy's under the National Health Service Scheme, but what about Guy's without its present Matron? I feel that I cannot sit down without paying a tribute to all that she has done for Nursing, for the Nursing School of Guy's



Fox Photos Ltd.

and for Guy's itself in many different aspects. I am measuring my words when I say that during the past eighteen years no single individual, man or woman, has done so much to foster and maintain all that is best in the Guy's atmosphere and tradition, and that, throughout our long history, there have been few who have been as successful in spreading the influence of Guy's. Her acknowledged and exceptional gift of talking naturally into a microphone has not only made Guy's known throughout the length

and breadth of the land, but, without any effort to do so, she has conveyed to her listeners what you and I know, that Guy's is a good place to live and work in, that it is intensely human and that the motto of its founder pervades his disciples. And if they haven't inferred that Guy's has been intensely fortunate to have such a Matron, they have been exceptionally dull.

Miss MacManus has played a very important part in education. She has an urge in that direction that she cannot curb. She has educated matrons, sisters and nurses; she has educated members of the Staff and house officers; she has educated Governors of Hospitals, Officers of Ministries, particularly of Health and Labour, members of the County Councils; and, finally, she has educated Clerks to the Governors and at least one Superintendent of the Hospital. In the earlier and more difficult stages of the War, whenever I said that something couldn't be done, her invariable reply was: "But, Professor Johnston, it *can* be done!" and done it was, even to the acquisition and erection of six enormous marquees in the precincts of the County Hospital, Pembury. She would say: "They don't know; we must educate them"—and educate them we did.

A born fighter—that is the Irish blood that flows, sometimes, riots, in her veins—she was never tired on behalf of her nurses. No matter what the odds against her, she would fight, plead and coax by turns till she got her point. Once achieved, it was relegated to past history. Never any song of triumph, merely preparation for the next piece of work. Courageous to a fault, she drove her ancient and rather decrepit motor-cars all over Kent, in the blackest of black-outs and the densest of fogs, braving alike the bombs of "blitzes" and the bullets of the Home Guard—and why? Because her nurses would have been disappointed if she had missed their Christmas party or some other party at Pembury, Orpington or Farnborough. If a bomb fell on or near any hospital in Kent, the Matron knew about it at once and within an hour she was there to sympathise, to encourage and to help, whenever help was needed. What a sense of duty, and she herself her sternest and only critic.

I could go on for a very long time on this topic. Her sympathy with the young and her broad-mindedness, her sense of justice and fairness, her reactions to opposition, her tactical withdrawals to gain strategic victories. She has had a glorious time at Guy's and I know she has enjoyed every minute of it.

We are living in a time of rapid transition and our main preoccupation must be to carry over into the new Guy's all that was best in the old. We are very lucky in that our new Matron has been bred in the Guy's tradition, and I don't think that I am very wide of the mark if I hint that her standard of values is not very different from that of Miss MacManus.

Let me say, in conclusion, how much I appreciate the privilege of being allowed to attend this wonderful meeting to-day and to speak to such an incorrigibly Guy's audience."

A TRIBUTE FROM THE ROYAL COLLEGE OF NURSING.

Miss MacManus, for two valued years the President of the Royal College of Nursing, is one of the few people who can do the impossible; only she, too, must have found that "the impossible is that which takes just a little longer." If, in the press of College affairs, there was a difficult committee to handle, a situation to save, an extempore speech to make, a telling broadcast to be delivered, two vital but simultaneous meetings to attend, important guests to welcome or a banquet to be graced in the name of the College, somehow Miss MacManus would fit these things into her day, and perform them with such accomplishment and distinction that those who called on her for help were torn between the temptation to plead for just one more service and the determination to be more merciful and restrained in future, to concede her some time for her other work—her own hospital and those short spells of leisure for books and fishing and the country life she loved.

Pressure of engagements always put a limit to the period Miss MacManus could spare for any office, but while she held it she gave it her full attention and loyalty. She was the valued member of many bodies and organisations, but she approached each one with complete singleness of purpose. As a member of the Council of the Royal College of Nursing she spoke with enthusiasm as and for the College; just as, being a member of the General Nursing Council, she spoke with authority and discretion for the nurses' statutory body. Again, as chairman of the Education and Training Sub-Committee of the Horder Committee on Nursing Reconstruction, she represented a variety of people with kindred interests, all bent on examining their evidence with open-minded detachment.

And yet, though there was no overlapping, one felt that the experience Miss MacManus acquired in these and other fields contributed to her wise handling of the business under discussion. Quick to sift the wheat from the chaff, she would steer her committee clear of irrelevant issues and muddled thinking. Minuting under her chairmanship was a joy. Briefing for the agenda rarely was. Pressure of work left too little time, and the briefing, as like as not, took place on the way upstairs to the committee-room. But the secretary of the moment need have had no qualms. Miss MacManus had grasped the salient points, and the meeting would record a series of orderly and far-reaching recommendations, with everyone feeling they had had a square deal and a fair hearing.

During her tours around the country, particularly as President of the College, Miss MacManus was always in demand for talks to school-girls. Her fresh approach, her command of words and her wide interests appealed to the younger generation. She was worldly-wise and yet could inspire them with a sense of idealism, and the College benefited from her labours. A charming guest at any gathering, if one thing more than another could bribe her to carry out some College duty far afield, it was the prospect of a day on a salmon river.

When Miss MacManus returns from her survey of nursing problems in the West Indies her desire for well-earned leisure will be treated with respect, but for the College at least, so long as Miss MacManus is within hail, the old conflict between exploitation of a great nurse and recognition of the rights of a human being to live her own life will begin all over again.

A Year Ago To-day

(May 21st, 1946.)

By DENNIS H. FORSDICK.

ONE year ago to-day there occurred an incident about which I should like to remind you. An event, witnessed by only a few, which took place near a small village, insignificant in size yet notorious in name, set amidst the beautiful forest land of North Germany. The name of the village was Belsen—a name remembered, no doubt, by all of us, yet one which so many are forgetting too quickly.

The incident, whose first anniversary falls on this date, was the ceremonial destruction by fire of the last hut in Belsen concentration camp, liberated by the British Army on April 15th, 1945. Around this last wooden hut there assembled a small crowd consisting of officers and men of the British Army, including some R.A.M.C. doctors, some British medical students, a few German civilians, and a few of the many unfortunate beings whose lot it had been to survive the horrors of this, one of the most terrible concentration camps set up by the Naz's.

Around us there stretched the black smouldering remains of the rest of the camp, the smell of burning mingling with that stench of decay and filth which still polluted the air. Here and there one could see the mounds of the mass graves, where uncertain numbers lay buried, and still, in the hollow at the far end of the compound, near which the ceremony was to take place, the tall chimney of the crematorium pointed its finger to the sky. In the ovens lay still the powdered remains of—how many ? Opposite, and a few yards from the hut there had been erected a small platform, and behind it a flag-pole. To the left of this there stood two Bren-gun-carriers, fitted with flame-throwers.

The ceremony was simple. A colonel made a short speech, some soldiers fired a salute to the dead, a Union Jack hoisted to the top of the flag-pole, paused, unfurled itself, was caught on the breeze, and waved over the scene. Two long red tongues of flame leaped from the gun-carriers to set the hut ablaze.

All simple and straightforward—yet sufficiently touching to produce in one those queer shivers down the back that some of us experience at the sight of a contingent of guards marching down The Mall, or the glimpse of bright uniforms at a military tattoo.

And then we cheered. The inferno before us grew brighter and hotter every moment. Although almost all of us were openly excited, even then some of the internees present wore that sadly apathetic countenance bred in them through years of bitter, inhuman suffering. They knew they had no homes, no families to return to when all this was over. The remains of what had been dear to them lay smouldering with the ashes

amongst which they stood. Here at Belsen, at Auschwitz, at Neuen Gamme, and at all the other hells they had seen, they had had all that was worth while in their lives taken from them, had been beaten and tortured and left with a sick mind and a broken body, with no hope for anything at all in the years to come.

Klein, the "mad doctor" of Belsen, has described the place as "a camp of death." If it had been just that it would not have been so bad, for, more than that, it was a place of everlasting disease in the minds of its survivors.

To-day, at the entrance to the camp, there stands this notice :—

THIS IS THE SITE OF
THE INFAMOUS BELSEN CONCENTRATION CAMP.
LIBERATED BY THE BRITISH ON 15TH APRIL, 1945.

10,000 UNBURIED DEAD WERE FOUND HERE,
ANOTHER 13,000 HAVE SINCE DIED,
ALL OF THEM VICTIMS OF THE GERMAN NEW ORDER IN EUROPE,
AND AN EXAMPLE OF NAZI KULTUR.

Lest the memory of such atrocities fades from our minds, let us remember this—there live still hundreds of thousands of wretched people whose lot it is to remember these things always. We who find it difficult to visualise these horrors, should consider it a duty to humanity never to forget them.

Correspondence

"THE UNEASY CHILD."

To the Editor of the GAZETTE.

SIR,—It would be a pity if the students who attended Mr. Layton's lecture on "The Uneasy Child" were to gather the impression that it is ever right or necessary to hold children down while anæsthesia is being induced. Suitable premedication with nembutal, or some allied drug, will ensure that the child comes to the anæsthetic room either asleep or at least sufficiently drowsy as to be indifferent to its surroundings. There can be no justification for submitting a child, certainly not a so-called "uneasy child" to this frightening ordeal, particularly in Mr. Layton's department.

I am, etc.,
DAVID ELLIS.

4, Priory Road, High Wycombe.

Sport and Hospital Information, etc.

Cricket

FIRST ELEVEN FIXTURES, 1946.

May 11th ..	Westcliffe-on-Sea	Westcliffe
18th ..	Old Whitgiftians	H.O.P.
25th ..	Bromley Town ..	H.O.P.

Guy's play Kings College Hospital in the first round of the Inter-Hospitals Cricket Cup at H.O.P. on Wednesday, May 22nd. The match starts at 11.30 a.m.

The full fixture list will be published in the next issue of the "*Gazette.*"

Notices

NATURAL HISTORY SOCIETY.

The Natural History Society, which was formed last term, with Mr. T. J. Evans as President and with a student-staff committee, will open this term's series of meetings with a talk on Meteorology on Monday, May 13th, 1946, at 5.15 p.m., in the New Theatre. Notices announcing future functions of the Society will be posted in the Medical and Dental Schools. G. M. P. COUPLAND,

Secretary.

THE INNOMINATE CLUB, 1921.

Will all members in favour of a reunion dinner at an early date please communicate with the Secretary as soon as possible ? When writing, please show present address clearly.

G. T. HANKEY.

79, Harley Street, W.1.

Births

DAVIES.—On March 24th, 1946, in Abadan, Southern Iran, to Pamela, wife of E. R. Davies, F.R.C.S.—a son (John Cradock).

SALMON.—On April 12th, 1946, at Guy's Hospital, to Maude ("Pip") (née King), wife of L. F. W. Salmon—a daughter (Elizabeth Ann).

SIGGERS.—On April 16th, 1946, at the Howard Nursing Home, Maidstone, to Rosemary (née Serraillier), wife of R. G. Siggers—a son (Mark Andrew), a brother for Suzanne.

Deaths

SHEPHERD.—On May 1st, 1946, at 48, Porchester Terrace, W.2, Sir Harry Percy Shepherd, Governor of Guy's Hospital 1922–1946.

EDS. { J.M.H. / R.H.N.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

WHEN we announced the re-opening of the College in "Passim" it had not occurred to us that an obituary of it had already appeared in the *Gazette*. Battered and inadequate it has risen again to confound the critics who believed and hoped that it had died in the big fire raid on London in 1941. Nobody could have foreseen, then, that the Residents would once more hold a dinner there and adjourn, afterwards, to their fine, reconditioned old sitting-room. This they were able to do, for the first time since that memorable raid and with much enjoyment, at the end of last month.

It may come as a surprise to the modern generation of students to learn that the College was considered, as long ago as 1937, to be an unfit place for students and House Officers to live in. The war has altered our conception of luxury and, even in its present state, the College compares favourably with the two other hostels now in use. The cries of derision that once were showered upon it have turned almost to songs of praise. Its days may be numbered, but it is now a very present help in time of trouble. "Farewell to the College"—an article which appeared in the *Gazette* in 1941—makes interesting reading to-day. The falsity of some of the remarks is apparent, yet the purport of others remains.

MR. C. H. KINDER, to whom we extend our good wishes, has been succeeded as President of the Residents by Mr. K. S. Maclean. The new Vice-President is Mr. C. K. Cole.

THE Editors have recently received an unusual souvenir from the Far East in the form of a five-dollar bill issued by the Japanese Government. The bill bears the following signatures, written on April 4th at 93rd Indian General Hospital—S. Bockner, V. Bockner, E. B. French, G. C. Kennedy, P. L. Masters, Z. F. Miller, G. E. Thomas and W. G. Tillman. These names will be familiar to many Guy's men, and we take this opportunity of thanking the signatories for sending us this original and interesting memento of what must have been a very pleasant occasion.

DR. STERLING BUNNELL, of San Francisco, Consultant for Hand Injuries to the United States Secretary for War, is visiting this country in June, and has accepted an invitation to give a lecture on "The Reconstructive Surgery of the Hand" at Guy's on Wednesday, June 12th, at 3 p.m.

THE Hospital had the honour and the pleasure of welcoming H.R.H. The Duchess of Kent on Monday, May 20th, 1946. After attending the Shakespeare Commemoration Service in Southwark Cathedral, she visited Victoria Ward and Diplock Ward, and then took tea in the Nurses' Home after presenting medals to a number of Sisters. Representatives of all branches of the Hospital gave her an enthusiastic reception, and we hope that it will not be long before she is able to visit us again. It is hoped to reproduce a photograph in the next issue of the *Gazette*.

THE Park has undergone a remarkable transformation during the past two or three months. It need never return to its former state, when it was a disgrace to the Hospital and served no profitable purpose. Several blades of grass are pushing their way through the bare patches and soon there will be sufficient of them to allow the

removal of the unsightly barriers. With the hottest days still ahead the Park will more than ever become a place for quiet, digestive meditation after lunch, when a reflective assessment of the morning's work decides the afternoon's undertakings.

THE need for economy in fuel is no less urgent now than it was in war-time. Mr. Shinwell's department is assiduous in its efforts to remind us of the coal shortage. Electricity, we believe, bears a very definite relationship to coal, and those who control the electric light system of the Hospital fail in their duty. The lights outside the Dental School, Hunt's House, in the Colonnade, over the main gates and elsewhere burn merrily from one day's end to the next. The benefit is non-existent and the wastage immense. If these lights were switched off, even for a short period in the afternoon, both money and fuel would be saved. It is hard to think of any reason why these lights should be on during the hours of daylight.

THE Theatre Club is shortly presenting "French Without Tears" to start a fund to provide wireless receiving apparatus for the Hospital. In an altogether lighter mood than any recent production at Guy's, this play would appear to be an eminently suitable choice. Mr. Terence Rattigan has had many brilliant successes to his credit since "French Without Tears" ended its long run in the West End some years before the war, but this delightful and invigorating comedy has lost none of its original appeal. Nor will it lose that appeal unless the years bring forth a generation of Englishmen deprived of their equanimity in a foreign land and their indifference towards a foreign tongue.

It is likely that the reputation of the Theatre Club will be further enhanced as a result of this forthcoming production, details of which will be found under "Hospital Information." We have been asked to state that students from other hospitals, as well as the friends and relations of those connected with Guy's, will be welcome at any of the performances.

WE confidently recommend the accounts supplied by our cricket correspondent to those of our readers who are normally bored by reports of sporting events. The XI have won four of their first five matches, the other ending in a draw. We congratulate them on this encouraging start to the season and marvel at the initiative of the batsman who found himself with an average of 236 after three matches.

Guy's beat King's College Hospital in the first round of the Hospitals' Cup by 232 runs.

Non-Purulent Pleural Effusions

BY J. J. CONYBEARE, M.C., D.M., F.R.C.P.

A Clinical Lecture delivered at the Medical School on Thursday, March 21st, 1946.

GENTLEMEN,—There are many causes of non-purulent pleural effusions. Some are passive transudates, often bilateral, occurring quite commonly in cardio-vascular and renal disease, such as congestive cardiac failure and chronic nephritis. In these cases the pleural effusion is always associated with other signs and symptoms which help to make the diagnosis unmistakeable. In nephritis, for instance, there is never a pleural effusion unless there is other evidence of renal disease such as œdema of the legs and ascites, and the same is true of pleural effusions associated with congestive failure. There will also be other features which make the diagnosis reasonably certain. There is no reason to discuss further the question of transudates except to remember that they are very unlikely to contain visible blood. The amount of protein is small as compared with that present in neoplastic and particularly in tuberculous disease, and the specific gravity is relatively low.

An important group of effusions are those due to carcinoma of the pleura. A pleural effusion occurring in a patient of middle age and over is much more likely to be due to carcinoma than to any other condition—that is, if the transudates in heart disease or nephritis are excluded. Pleural effusions of this type are usually hæmorrhagic and sometimes blood is present in large amount, but it must not be argued that because

an effusion is clear it is not due to malignant disease ; although the majority are blood-stained, this is not universally true. The primary growth may be anywhere—prostate, breast, stomach—and may metastatise into the lung or pleura. Occasionally, a primary growth may not produce striking symptoms and a pleural effusion may be the chief feature noted when examining the patient. Hodgkin's disease and lympho-sarcoma not infrequently produce pleural effusions in the later stages of the disease.

A less frequent cause is pulmonary infarction. This rarely causes much difficiulty in diagnosis. The patient gives a history of a sudden and severe pain in the chest which comes on instantaneously. Very often there is shortness of breath as well. Within a day or so blood-streaked sputum appears. In addition there is often an obvious cause for the condition, such as a thrombo-phlebitis.

Non-purulent pleural effusions may occur in pneumonia. We have been rather accustomed to think of pleural effusion in pneumonia as being likely to be pus rather than clear fluid, but quite a number of cases of pneumonia are associated with an effusion, often not particularly large, which is both sterile and relatively clear. If it is examined microscopically it is found to contain cells, the great majority of which are polymorphonuclears and not lymphocytes.

The differentiation of effusions found with pneumonia and those due to tuberculous pleurisy is often difficult. The history is sometimes of value. In pneumonia the onset is very abrupt. There may be a rigor and sharp pain in the chest, and the patient, who had got up perfectly well in the morning, may by afternoon have a high temperature and other symptoms. This is not so often the case with tuberculous pleurisy, where the onset is often more gradual and the patient may have been out of sorts for some months. He usually gives a history of pain in the chest which has lasted a day or two and then passed off, and then a more severe attack of pleurisy associated with effusion has occurred. Inquiry should be made whether the patient has been in contact with an open case of tuberculosis or has a tuberculous family history. Tuberculous pleurisy is mainly a disease of young adult life.

In tuberculous pleurisy the effusion generally occurs rather early in the illness. The initial pain in the chest passes off within a couple of days and the patient rapidly develops the physical signs associated with fluid. In pneumonia the effusion usually arises considerably later in the illness. It is probable that the use of sulphonamides and penicillin in pneumonia has increased the frequency of non-purulent effusions.

Another point in the differentiation between tuberculous effusions and those associated with pneumonia is that tuberculous effusions often become large very rapidly. Slight dullness is found at the base on examining the patient on one day, and on the next he is dull over almost the whole of the affected side of the chest.

These are some of the points that help in differentiating these two conditions. If fluid is suspected the chest should always be explored and a specimen withdrawn for examination of the cells. This is extremely important. In effusions associated with pneumonia the cells are always predominantly polymorphonuclear, while with tuberculous effusions they are predominantly lymphocytic, particularly after the fluid has been present for two or three days. Sometimes in the very early stages there may be a fair number of polymorphs as well as lymphocytes, but the former tend to disappear and the effusion becomes increasingly lymphocytic.

The X-ray appearance is usually fairly decisive as to whether fluid in the chest is present or not, though it may sometimes be misleading if the pleurisy starts in the interlobar fissure. As a rule, the costo-phrenic angle is filled up at an early stage and the X-ray signs are characteristic.

A pleural rub may be present both in pneumonic and tuberculous pleurisy. Often, however, the pain is so severe that the patient cannot breathe reasonably deeply, and thus it may not be possible to hear any pleural rub. As soon as fluid is formed the layers of the pleura are separated, and therefore the rub will disappear. In any area of the chest where pleural friction is heard there cannot be fluid.

A word or two about the physical signs of pleural effusion. Little information is likely to be obtained from inspection, as non-purulent effusions do not produce bulging of the intercostal spaces. It may be possible to see that one side of the chest is relatively immobile.

On palpation a most important physical sign is absence of tactile vocal fremitus over effusions. The apex beat with large right-sided effusions may be found to be out towards the left axilla. If the effusion is on the left side the apex beat may be beneath the sternum and is not palpable.

On percussion there is stony dullness over an effusion of any size. Other signs described such as Skodaic resonance and Grocco's triangle are of academic and historical interest only, particularly in these days when mobile X-ray plants enable good X-ray films to be taken when the patient is in bed.

On auscultation the breath sounds in effusion are diminished or absent, but auscultatory findings may sometimes be misleading and must never be accepted as final, particularly if other evidence suggests that fluid may be present. Tubular breathing and ægophony may be found at the upper level of the effusion.

There is also evidence of the shift of the heart and the mediastinum if the effusion is a large one. Large right-sided effusions will push the heart over to the left. If the apex beat cannot be felt it may be possible by auscultation to judge that the heart has moved. Thus it may be found that the heart sounds are best heard under the sternum or even to the right side of the sternum, owing to the heart being pushed across by a large left-sided effusion.

It is important to realise that physical signs in pleural effusion may be deceptive. It must not be assumed that because there is tubular breathing that there cannot be an effusion. With all physical signs it is very important not to draw too hard-and-fast conclusions from them As the fluid diminishes by absorption or because it has been aspirated, tubular breathing may develop over wide areas ; also very often a pleural rub is heard, which may be very widespread as the fluid absorbs and leaves the two layers of pleura in contact rubbing over one another. Any patient who has a pleural rub should be regarded with suspicion and kept under strict treatment. They should always be kept in bed until the rub disappears.

TREATMENT OF TUBERCULOUS PLEURAL EFFUSIONS.

The first thing in the treatment of a pleural effusion is to stop the administration of sulphonamides. Most patients with tuberculous pleural effusions willl, in the early stages of the illness, have been put on sulphonamide or penicillin owing to pain in the chest and breathlessness which has been taken as due to pneumonia. Only too often more care in examination and a leucocyte count would have rendered the diagnosis obvious.

Good nursing is essential. The patient should be in hospital and should never be kept in a house where he cannot get adequate day and night nursing. The chest should be explored and a small amount of fluid withdrawn for diagnostic purposes. A local anæsthetic should always be used, as an aspiration may be extremely painful. As it may be necessary to aspirate the patient on several occasions in order to remove the fluid at a later stage it is important to cause him the minimum discomfort. It is very little trouble to use a local anæsthetic and, beyond the first prick of the hypodermic needle, a patient undergoing an aspiration of the chest should feel nothing whatever.

Having withdrawn a specimen of fluid it is very important to have it examined microscopically from the point of view of determining whether the cells are polymorphonuclears or lymphocytes, because in tuberculous effusions the cells are predominantly lymphocytic. A specimen of fluid should be sent to the bacteriological department to be cultivated and also for inoculation into a guinea-pig and culture for tubercle bacilli. The results of these investigations will not be available for several weeks. Even if these investigations are negative it should be assumed that if the cells are predominantly lymphocytes the condition is tuberculous, unless there is some other explanation for the pleurisy.

Nothing in particular need be said about diet. During the acute stage with pain or high temperature the patients will not want very much to eat. Later on they can be given as much as they will take. They should be X-rayed on admission and again at weekly intervals until most of the fluid is absorbed. The point about frequent X-rays is that as the fluid absorbs the lung re-expands, and a tuberculous focus may be shown by the X-ray in the expanding lung. If such a focus is found it may be advisable to replace the effusion by air and turn the condition, first, into a hydro-pneumothorax and eventually into a pneumothorax, which the patient will have to maintain for a number of years. If the lung is allowed to expand following a pleural effusion it will probably be impossible to induce an artificial pneumothorax at a later date because the pleura will have become adherent. It is important, therefore, to do serial X-ray examinations at short intervals so that a tuberculous focus in the lung can be detected at a stage when air can be introduced to replace fluid.

Another important point in the treament is the question of aspiration. There are certain definite indications for aspiration. The most important of these is respiratory distress whilst the patient is at rest. If the patient is obviously breathless while in bed it is advisable to withdraw a certain amount of fluid. If the effusion extends up very high—*i.e.*, to the second rib—this generally means that the effusion is so large that aspiration is required. The same applies if there is a marked displacement of the heart and mediastinum. If the amount of fluid is not diminishing after three or four weeks it is often wise to aspirate a certain amount of fluid because this procedure seems to stimulate absorption.

These, then, are the indications for aspiration, the most important of which is respiratory distress. When aspirating, the important thing is not to take off too much at a time and to withdraw the fluid very slowly. If the patient be attached to a large aspiration bottle under a high negative pressure, several pints can be drawn off in almost as many minutes. This produces sudden re-expansion of the lung and often great respiratory distress with, sometimes, paroxysms of coughing and collapse. Also it is very liable to light up a tuberculous focus which may happen to be in the underlying lung. Never, therefore, draw off large quantities of fluid very rapidly. The best method is to aspirate with a relatively small 20 c.c. syringe and a two-way tap, which means that withdrawal of fluid must necessarily be slow. As a rule, not more than 15 oz. should be withdrawn at a time and never over 20 oz. If the effusion is very large and the patient breathless, fluid should be withdrawn on successive days rather than aspirating a large amount at one time.

How long should the patient remain in bed ? Pyrexia and pulse-rate are obviously two important factors. So long as temperature and pulse-rate are raised he will have to remain in bed. Absorption of the fluid is another point. The persistence of a rub is also an indication that the condition is active and that the patient should still be in bed. The blood sedimentation rate is also a very useful guide. The sedimentation rate, taken when the patient first comes into hospital, will usually be between 40 m.m. and 100 m.m., and it will fall as he improves. The patient should not, as a rule, be allowed to leave hospital until it is down to normal—that is, 8 m.m. or below. It is true that there are patients who have persistently high sedimentation rates of 20 or so, and in such cases this isolated finding must eventually be neglected. But, generally speaking, the sedimentation rate is of great value and should be taken systematically at weekly intervals and considered in conjunction with the clinical features in deciding what amount of activity the patient shall be allowed.

However soon the temperature and pulse come down a patient with a tuberculous effusion should not be allowed to get up for six weeks. This minimum should be enforced, however minor the symptoms appear to have been. Very often, if the temperature or other symptoms have persisted, patients must be kept in bed for three months or longer. Patients should never be allowed to return even to relatively restricted home conditions in less than three months. Very often they should be in hospital for much longer. The usual minimum is six weeks in bed and another six weeks under strict control in hospital. They should not go back to an ordinary sedentary life earlier than six months from the beginning of the illness.

Before the war I often advised sending these patients to a sanatorium, but there are certain disadvantages in sending such people to a sanatorium in that they are marked out as tuberculous amongst their friends. Moreover, a good many sanatoria at present are short of staff and unwilling to accept these cases. The ideal conditions are those of a good convalescent home where they can take controlled exercises and have X-ray examinations and basal sedimentation rate estimations at monthly intervals. If they have good homes where they can be looked after reasonably well they can go there, but, unfortunately, they often feel so well that if not under strict control they do stupid things. There are many disadvantages in treatment at home, partly because they are not under discipline, and partly owing to lack of facilities for close supervision.

If patients go back to work after six or nine months it is very important that they should continue to have X-ray examinations at regular intervals—every three months for the first three years. The same thing applies to the estimations of the blood sedimentation rate. Physical examination of the chest is no substitute for an X-ray examination. The periodical X-ray examination will enable a tuberculous focus to be detected reasonably early. If a person who has had a pleural effusion develops a cavity in the lung on the side on which he had pleurisy, adhesions will almost certainly prevent the induction of an artificial pneumothorax. Such cases may eventually

require thoracoplasty. It is therefore essential to detect a developing pulmonary lesion early, and this can be done best by X-ray examinations every three months. The blood sedimentation rate may also give a clue if, having been normal, it starts to rise. Even though the X-ray examination shows nothing it will be well to examine such a patient again within a month instead of within three months. A weight-chart should also be kept, and the patient should be under general supervision as regards health. Physical examination of the chest is unlikely to be of any value.

Those who have had tuberculous pleurisy are notoriously liable to develop pulmonary tuberculosis, particularly if treatment has been unduly curtailed. The majority of those who develop phthisis do so in the first two years after the effusion. All cases should remain under supervision for five or six years with three-monthly X-rays for the first three years and subsequently at six-monthly intervals. It is unwise for such persons to reside in tropical climates, where infections such as malaria and dysentery may lower resistance and predispose to the development of phthisis.

House Officers—Sector 10

MAY 1ST TO JULY 31ST, 1946.

Remaining	*New Appointment*	*Transferred from*	*Transferred to*	*Retiring*
GUY'S.				
Allanby, K. D. (B.2)	Scott, L. G.*		Topham, H.W. to Pembury	Astbury, J. S.*
McVicar, G.*	Rochford, J. P.*		Sidebotham, R. E. to Farnborough	Kinder, C. H.
Buckler, F. R.*	Pearson, G. M.*		Crook, J. C., to Pembury	O'Keeffe, D.
Cole, C. K.*	Martin, J. K.*			Gardner, C. S.*
Cormac, C. D.*	McLaren, L. R.*			Leeming, J. A. L.*
Jenkins, J.T.W.C.*	Stone, A. W. P.*			Shaw, J. F.
Lewin, D. C.*	Rey, C. H. J.*			
McLean, K. S.*	Holman, J. C.*			
Stafford-Clark, D.*	Finnegan, T. R. L.			
Stewart, I. McD. G.*	Joiner, C. L.			
Blundell, J. E.	Brunsdon, D. F. V.			
	Dicksom, J. R.			
	Robinson, R. G.*			
FARNBOROUGH.				
	Horan, D. G.*	Sidebotham, R.E. from Guy's		
	Maile, W. B. D.*			
ORPINGTON.				
Parry, T. C. L.	Goulder, R.V.H.			Montgomery, P. R.
Dixon, H. G.	Burns, T. H. S.			Neve, C. R.
	Mills, R. P.*			Wadia, R.*
				Walter, K. H.*
PEMBURY.				
Cree, W. W.	Coling, P.	Crook, J. C., from Guy's		Griffiths, J. E.
Shaw, C. S.	Neville, N. A.*	Topham, H. W., from Guy's		King, M. B.
				Symonds, B. E. R.
SOUTHERN.				
Ward, M. W. P.	Pearson, C. M. G.	Bayliss, J. C., from Joyce Gn.		Huntley, J. D.
Woodman, G. M.	Bearn, A. G.			Jones, T. J.
	Hutchison, J. G. P.			Roberts, C. G.
JOYCE GREEN.				
Hallinan, W. M. C.	Gurassa, W. P.	Topham, H. W., from Guy's	Bayliss, J. C., to Southern	O'Connor, D.
	Jackson, F. L.			
	Owen, R.			
QUEEN MARY'S.				
	Parker, R. A.			Fifield, J.

* Ex-Service.

A Tour of the United States Plastic Surgery Centres

By PATRICK CLARKSON, M.B.E., F.R.C.S.

PART I.

THESE notes describe a tour which was undertaken on orders from the Director-General, A.M.S., during the last fifteen weeks of 1945. Its purpose was to visit and observe methods of reparative surgery at U.S. Army, Navy and Civil Plastic Centres. The material here is based on a diary, and is chiefly concerned with travel experiences and general affairs in the United States to-day; it has been found impossible to exclude some reference to gastronomic life.* General surgical and plastic matters of special interest are included, but full technical reports on these matters have already been rendered to the War Office, and the bias of this account is more frivolous than technical.

I left B.L.A. for England at six hours' notice. This method of leaving one's unit has certain unexpected advantages. It made certain that the packing of three years' accumulated personal and surgical *bric-a-brac* from North Africa and Italy had to be done by my batman, poor soul, and sent to England *via* the M.F.O., with possible savings in customs.

It was pleasant to leave Prestwick at eleven at night and have breakfast in Montreal about nine the next morning. This Atlantic "hop" by Liberator was enlivened by the company of my fellow clinical, Mr. M. R. Kark. All those who remember him at Honor Oak Park would have admired his appearance in a 14th Army hat. I gathered that his work with the 14th Army had been the study of Environmental Medicine, including studies of the reactions of troops under battle conditions, with special reference to determining the factors that produced exhaustion in units in the Burma Campaign. He told me the result of his observations—psychological, biochemical, entomological and medical—over two years, was the conclusion that when a Unit "had had it" in Burma, it "had had it."

The trip from Montreal to Washington was made *via* New York, where a stop was made for free lunch of ice-cream and coffee at a Red Cross Canteen. Sunday is a bad day to arrive in Washington. Five hotels were visited before I was admitted to one, and by that time I was late for tea. To a stranger Washington to-day is very delightful. I belive its population has nearly doubled since the War and is now nearly 1.5 million. It is extremely cosmopolitan, full, animated, friendly and, seen from the air or on the ground, very lovely. It can be very hot indeed, and battle-dress is no dress for September or for October. During my later visits I stayed at the Statler Hotel, which is the most modern of U.S. hotels, and an extremely comfortable place for the traveller. The bedrooms are all made into sitting-rooms during the day, have a radio, air-conditioning and, of course, a bathroom with three temperatures of water—boiling, cold and icy. When you enter the bathroom for the first time, everything in it, including the seats, is wrapped in paper labels with "Sterilized for Your Protection" printed on them. The cost of all this is about $6-8 a day.

On this first visit to Washington calls were paid both to the Walter Reed Hospital and the Bethesda Naval Hospital. The Walter Reed is on the outskirts of Washington—a number of lovely mellow red, ivy-covered brick buildings. It has Amputation, Chest, and Orthopædic centres. The Bethesda Naval Hospital is rather farther out. It is of the appearance and about the size of London University. Captain Craig, of the Mayo Clinic, was Chief of Surgery there when I visited it, and Comm. George Webster was in charge of plastic surgery.

At this stage my whole tour was planned, under the direction of the Surgeon-General's Department, who gave me every advice and assistance in planning my time to maximum advantage, and full authority to visit any medical installation.

There were then in the U.S. over sixty Army General Hospitals, of 2,000 to 5,000 beds. Some of these were in permanent hospitals like the Walter Reed and the Letterman in San Francisco; others were in former luxury hotels like the Green Briars,

*The propriety of references to good eating is doubtful. Nevertheless, good eating is a pleasant feature of any traveller's experiences and memories of the U.S.

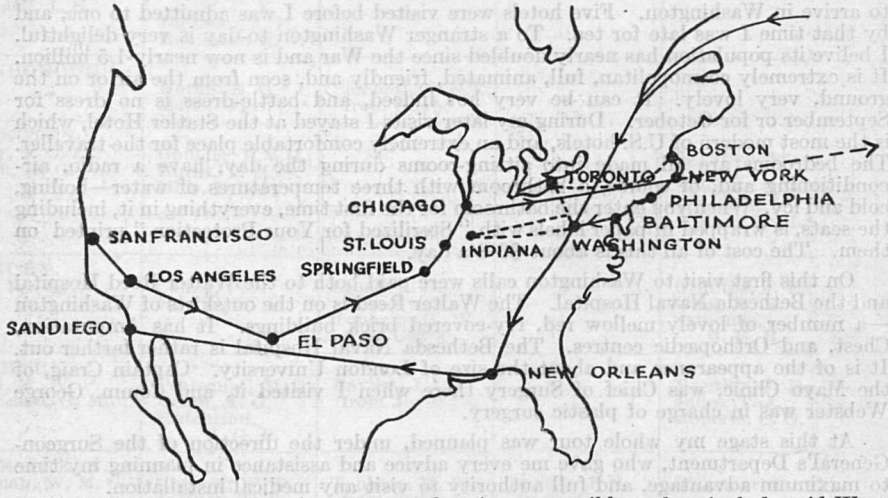
White Sulphur Springs and hotels, in Florida and Atlantic City; others, still, were in new wooden hospitals. These wooden one-storey hospitals, built since 1941 in rural surroundings (like the Dibble in California and the O'Riley in Missouri), make most attractive medical units.

Special centres—Orthopædic, Neurological, Plastic, Paraplegic—are, for the most part, in the same nine general hospitals. This grouping of the specialties in the same hospital and under the same roof, is a basic factor in ensuring the best advantages of specialist treatment for the patient. The active co-operation of specialist units is reflected in the very high numbers of beds in the Plastic Centres, 800 to 1,800. Only a third of these are face and jaw wounds; the rest are body plastics for patients who have bone and nerve lesions under treatment at the other special departments. These bed states are relatively enormous considering that the U.S. casualties were comparable in numbers to our own. The conclusion forced on one is that unless the Plastic Unit is under the same roof as the Neurological, Orthopædic, and Hand Units, it does not enjoy its full scope; conversely, the other Special Units, especially the Orthopædic, are best off when in the same hospital, as this ensures the best soft tissue repair for their cases at the earliest possible date.

The Civil Plastic Consultants to the Army are Dr. Jerome Webster, of New York, and Dr. Robert Ivy, of Philadelphia. The biggest of the Plastic Centres was that of Colonel J. Barrett Brown, at Valley Forge, where there were 1,800 plastic beds.

The Naval plastic centres are at Washington, San Diego, Oakland, Great Lakes and Long Island, and are most active centres of 100–300 beds.

At the U.S. civil plastic centres it was a great pleasure to find that the senior American plastic surgeons, Dr. Staige Davis, of Baltimore, and Dr. Vilray P. Blair, of St. Louis, were both in active practice and able to receive me. It may be of interest to note that there are nearly 150 accredited plastic surgeons in the States now. To be accredited, a surgeon has to have done two years General Surgical Registrarship and two years' Plastic Registrarship at recognised hospitals. This insistence on a general training for a full time speciality which tends to be rather sequestered is execellent. I visited over a dozen busy civilian plastic surgeons in their practices. The great bulk of their work was for trauma of face and hands, congenital deformities, burns, and repairs for facial malignancies. Only 5–10 per cent. of the cases treated by these accredited surgeons was cosmetic, and of the cosmetic operations by far the commonest was that for nasal reduction.



My tour was planned to be as comprehensive as possible and to include mid-West and Californian Centres, and Naval and Civil as well as Army Plastic Centres. The map indicates the itinerary (the first half of the journey is shown in a straight line, the second in dotted lines). It was my good fortune to have been travelling armed with a sheaf of letters from Sir Harold Gillies to his old pupils and his friends who are everywhere in the States. I was given the kindest reception everywhere, and am particularly

grateful for the kindness with which individual surgeons interrupted their busy days to show me every aspect of their work, in theatre and wards.

This first section of the diary concerns the tour from Washington to the West Coast *via* New Orleans and back to New York *via* the Middle West. Most of this tour was by air. The air journey to the West was fairly smooth; but pressure of returning Pacific troops meant that a non-priority traveller on the Westward journey was subject to constant "bump-offs." I spent many hours in airports across America and for the first time for many years became fairly up to date with my correspondence. These airports are extremely comfortable. Many of them have lovely rooms. All of them have excellent restaurants, bookstalls, and barbers' shops. The service everywhere is most efficient and polite. In my experience the planes are punctual. If you had a priority air travel was by far the most efficient and pleasant means of transport; but it was sometimes a relief to be travelling by Pullman and know what time you would leave and arrive.

My first hop from Washington was to New Orleans to visit Professor Neil Owens, who has the Plastic Chair at Tulane University. This was an excellent introduction to busy academic and professional life in the U.S. It was also a most kind and expert introduction to the New Orleans cuisine. This is a happy blend of the best traditions of American, Spanish and French cooking. There are at least three very notable restaurants—Antoine's, Arnaud's and Broussaud's. A classical meal in New Orleans would be: Shrimps Arnaud (very hot sauce), turtle-soup, steak with oysters, and café Brulot (which is brandy and coffee, a concoction which flames as it is poured). Another local dish is Oysters Rockefellow. These are cooked oysters with a green hot sauce, an altogether an excellent way of serving oysters other than first class.

DR. RUDOLPH MATAS

While in New Orleans I called on Dr. Rudolph Matas, father of modern vascular surgery. At over eighty Dr. Matas is actively concerned in writing the history of Louisiana. He has recently written a biographical study of Crile, Kelly and Lane, three surgeons whom he knew well and considered to have made especially distinguished contributions to the surgery of their time. In this study Dr. Matas has included not only the surgical contributions and teachings of these surgeons, but also a comparison of their philosophy and religious beliefs. Dr. Crile's rationalism is well known and well expounded by himself. Dr. Kelly was a devout Roman Catholic. Dr. Matas had abundant material about the beliefs of both to draw from; he had been less sure of his ground in this section of his study of Sir William Arbuthnot Lane. The day of my call was the same as that of Dr. Prudente, of San Paulo, Brazil, who brought to Dr. Matas records of his success in ligature of the abdominal aorta for aneurysm. Dr. Matas said that this was the third successful case to be recorded. Dr. Prudente was also armed with a colour film of his two-stage breast reduction operation. It was clear that he practises a very wide range of surgery in Brazil.

Dr. Owens' work in the treatment of burns is well known and cases of severe burns come to his wards from a wide area of the States. He is an advocate of local compression; as applied by Dr. Owens these dressings do compress. He has designed a fine mesh rayon for contact with the burnt surfaces (or with any granulating surface). This rayon (Winchester rayon) is permeable, but has a very low co-efficient friction and its interstices are too small for the ingrowth of a capillary loop. It is therefore a very atraumatic dressing which does not cause maceration. Dr. Owens insists on the need

of an impermeable layer outside the thick layer of cotton waste and gauze which covers the rayon, to prevent the ingress of infection from blankets to burnt surface.

A lively interest is taken in politics in New Orleans and extended to bell hops and taximen. It was difficult always to remember Mr. Churchill's maxim for political conversation when travelling abroad. However much you feel that the question should never be asked, point-blank questions about your opinion, on every aspect of Socialism and the present Government, are difficult to counter. Mild evasions by no means gave universal satisfaction.

During my stay in New Orleans I was most kindly taken by Dr. Howell one hundred miles up the Mississippi to visit Oak Alley, property of Mr. Stewart. This is a very lovely example of a Louisiana plantation and of colonial architecture. The estate by the side of the Mississippi has an exceptionally broad and beautiful alley of oaks. On the branches of these oaks is hanging the beautiful but slightly eerie Spanish moss of the State.

The journey from New Orleans to San Diego on the Californian-Mexican Border, was *via* Dallas, El Paso, and Tuczon, Arizona. San Diego is a thriving, bustling naval base, full of sailors and marines, male and female. The bustling frontier atmosphere was emphasised in the hotels. I stayed at the hotel which was recommended by British Army Staff at Washington as the most comfortable and that generally used by our people travelling on duty. It was the biggest and, although cheap, the most expensive in San Diego. I mention this because of the curious nocturnal customs there. At night armed marine guards paraded the corridors and entered any bedroom, at two-hour intervals, whose door was unlocked. (I had four of these visits my first night.) Armed guards stand on the stairway and lift entrances at night, and a chit from the hotel management, made out for that particular night, was necessary to obtain entry to one's room. The whole arrangement made one wonder what was going on at the smaller hotels near the station, to which I might easily have gone had this hotel not been nominated in Washington.

The object of my visit to San Diego was to see the Naval Plastic Centre of Captain Kirkham. This was at the Balbao Naval Hospital, which is of special interest in being the largest in the United States. It has 12,000 beds. As at the other Californian Centres, the majority of the casualties came from the Pacific Theatre. Captain Kirkham is a Texan who was born in England and was at Bedford School. In his Centre (which was of two hundred beds) there were examples of every type of plastic repair. He makes extensive use of preserved cadaver cartilage for contour restorations. The costal cartilages are dissected out at post-mortem and preserved in a bottle of 1/2000 menthiolate which is changed every month. Inflamatory reactions about the cartilage are rare. Dr. Lyndon Peers has shown that unlike autogenous cartilage it is not replaced by living and growing cartilage; it is therefore probably not suitable for the nasal repairs of children.

The Surgical Service at Balbao is directed by Captain Howard Gray, of the Mayo Clinic. Captain Gray saw much service with the Navy in the Pacific, and was at more than one of the landings. He spoke of the special difficulties for the medical services which occur when the beach-head remains very narrow for several days, and the whole area is under small-arms fire from snipers. It may be impossible to uncrate the heavier equipment of evacuation hospitals until the beach-head has been extended two to three miles in depth. This happened at Iwo and, as a consequence, most of the major surgery in the early stages could only be done on hospital ships, but on account of Kamikazes hospital ships could only come in for wounded at night.

During this stay in San Diego Captain Kirkham took me across the Mexican border for lunch, a very agreeable peppery lunch, with excellent Mexican beer. The meal was the happiest aspect of a happy visit, as subsequently one Mexican dealer sold me a Parker 51, of the value of $15, for double this price, and another six Mexican nylons for $2.50 each, more than double theirs.

While at San Diego I dined with a marine-flyer, a commander, who was staying at the same hotel. He was a young, very fit-looking officer, who, so he told me, was celebrating his acquittal from a court-martial charge of barbarity. His story was that, earlier in the War, he had been shot down into the sea by what he had thought was an innocent fishing-boat. He was rescued, but subsequently never made that mistake again. Everything that floated he went down on to with all guns on his plane firing. He had destroyed many fishing-boats. This had eventually led to his court-martial. He was a friendly and cheerful personality, gave the impression that he had

made this wrong decision several times, and would do it again rather than risk finding himself in the ditch. It was easy to understand the decision of the Court; the fault is in War, not the man.

San Francisco seemed as full of Service people as San Diego. My first call was on Dr. George Pierce, with whom I had three very busy days, during which he demonstrated a very wide variety of plastic problems and methods of repair. It was my good fortune to see in his clinic some very excellent contour restorations by the use of dermis and dermo-fat grafts and by preserved cartilage. Dermis and dermo-fat grafts provide an excellent soft contour restoration for cheeks, lids and lips. Allowance must be made for 25–30 per cent. shrinkage during the first year.

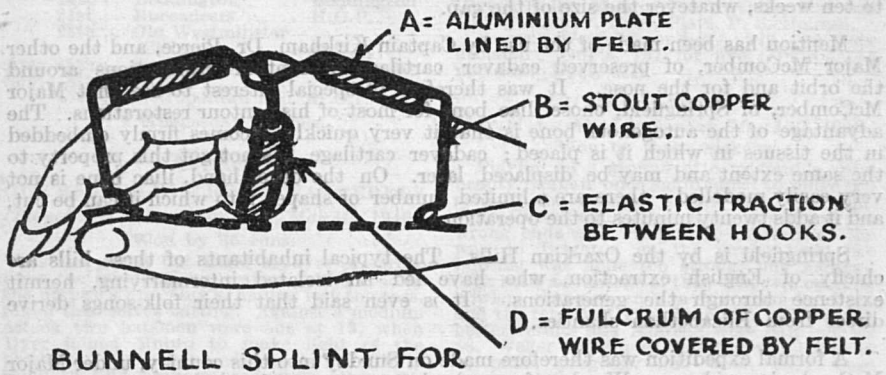
Dr. Pierce's kindly hospitality extended to me the temporary membership of his club, which has a superb Californian cuisine. He introduced me to the small, sharply-flavoured Gulf shrimps, the delicate flavour of the unexportable Cranway melon, the Californian oysters which you eat by the hundred not by the dozen, the superbly cooked steaks of his club, and its excellent '37 Pontet Canet.

I left California to stay at Menlo Park, at the Dibble General Hospital commanded by Colonel Paul Steit. The Dibble General is beautifully situated in most attractive Californian country and sunshine. It is a lovely hospital, even by U.S. standards.

Here, in addition to Orthopædic and Plastic Centres, there is one of Dr. Bunnell's Arm and Hand Centres.

The organisation for hand wounds in the U.S. Army has been under the personal supervision of Dr. S. Bunnell, who has been Consultant to the Secretary of War for Hand Injuries. It is, of course, on Dr. Bunnell's pioneer work that reconstructive surgery of the hand all over the world is based to-day. There are nine Army Hand Centres which are sited at the same General Hospitals as Plastic Centres. The hand surgeon works in the closest collaboration with the plastic and orthopædic surgeons. The results of this organisation and of the work in these centres are most impressive. This is particularly so of complex injuries of the hand in which there is loss of cover, of tendon, of nerve, and of bone. Under Dr. Bunnell, the U.S. undoubtedly leads the world in this branch of reconstructive surgery.

It would be quite impossible to attempt a full clinical account in this diary, but I cannot leave the subject of hand surgery without reference to the operation of capsulotomy. This is an example of a very good operation which has gone out of fashion in some countries for no very good reason. I always believed that there was no future in capsulotomy of finger joints, that indeed it was only a little less harmful than manipulation of the fingers. For some time such teaching was common. Indeed, the story of the British orthopædic surgeon who visited a theatre in one of the U.S. Hand Centres at the time a capsulotomy was being performed, and said: "We learnt to give up that


A= ALUMINIUM PLATE LINED BY FELT.
B= STOUT COPPER WIRE.
C = ELASTIC TRACTION BETWEEN HOOKS.
D = FULCRUM OF COPPER WIRE COVERED BY FELT.

BUNNELL SPLINT FOR TRACTION ON EXTENDED METACARPO-PHARANGEAL JOINTS

operation twenty years ago" was often quoted to me. I saw some thirty cases of hands in which the capsules of the metacarpo-phalangeal or inter-phalangeal joints had been divided, or had had an elipse excised from them. In all cases a permanent and marked improvement in range of movement and function had resulted. Dr. Bunnell emphasises the importance of light continuous elastic traction for a few weeks in the post-operative care of these cases. Diagram II illustrates the splint which he has designed for these cases, and for others in which light elastic traction on the metacarpo-phalangeal joints is wanted. It is light continuous elastic traction (as opposed to intermittent or vigorous) that gives good results in the restoration of function to the hand.

By a very happy piece of good fortune my visit to Dibble General Hospital coincided with a visit of inspection of Dr. Bunnell. I was able to see him examine and plan the repair of over fifty hand wounds, and to see him repair some cases of tendon, nerve and bone loss. Subsequently, I met Dr. Bunnell doing one of his tours of Hand Centres at several points across the States. He tells me that he has personally examined over four thousand hand wounds in this War.

The Plastic Surgeon at the Dibble is Major McComber, and his service is especially notable for the very high finish of the results. A special point in his repairs, by cross-limb and belly-to-arm flaps, is that the base of the flap is never left raw, but is covered by a free graft which extends over the secondary defect and across the base of the flap up to the point of its attachment. This was the first time in which I had seen this manœuvre adopted routinely. It was very enjoyable to visit a clinic and see a policy of having *no* raw surfaces anywhere completely implemented.

From Dibble I went to Springfield, Missouri, *via* Los Angeles and El Paso. At Los Angeles I met Dr. Kiskadden, who practises plastic surgery there; and I ate with Dr. Bunnell and a naval flyer, just back from Nagasaki. The flyer had nothing to add to the atomic bomb details already given in *Time* of that week.

The Plastic Centre at Springfield is under Dr. Douglas McComber. It is deep in the Middle West and next to the Ozarkian Hills. Major Douglas McComber, who is a cousin of the Major McComber at Dibble General, served for a long time at the Churchill Hospital in Britain, and will be remembered by many here. He has a very large Plastic Service at the O'Riley General Hospital. Of his 1,500 beds about one-quarter are cases of face and jaw wounds.

With Major Kaleen he had about three hundred jaw fractures under treatment. It was of interest to note that the routine bone graft for the jaw at this centre was a block of iliac crest. Major Kaleen had done about eighty of these grafts and showed me many of his cases. As when a rib is used clinical union is expected at about eight to ten weeks, whatever the size of the gap.

Mention has been made of the use by Captain Kirkham, Dr. Pierce, and the other Major McComber, of preserved cadaver cartilage in contour restorations around the orbit and for the nose. It was therefore of special interest to see that Major McComber, of Springfield, chose iliac bone for most of his contour restorations. The advantage of the autogenous bone is that it very quickly becomes firmly embedded in the tissues in which it is placed; cadaver cartilage has not got this property to the same extent and may be displaced later. On the other hand, iliac bone is not very easily modelled; there are a limited number of shapes into which it can be cut, and it adds twenty minutes to the operation.

Springfield is by the Ozarkian Hills. The typical inhabitants of these hills are chiefly of English extraction, who have led an isolated intermarrying, hermit existence through the generations. It is even said that their folk-songs derive direct from Elizabethan shanties.

A formal expedition was therefore made on Sunday into this country, under Major McComber's guidance. Wooden farm shacks were seen, but no inhabitants with shot-guns or corncob pipes, or who would in any way have attracted attention in Broadway or Oxford Street.

A meeting of the Plastic and Reconstructive Surgeons of America was held in New York on October 10th. For this reason only short visits were possible to St. Louis and Chicago, which lay on my route across the States from mid-West to New York.

Sport

Rugby

SEASON 1945–6.

Played	*Won*	*Drawn*	*Lost*	*Percentage*
35	17	3	13	56

Total points (*for*), 355.
Total points (*against*), 302.

These points were made up as follows :—

	Tries	*Converted*	*Penalty Goals*	*Dropped Goals*	*Tries*
Guy's	35	16	6	71	
Opponents'	28	11	9	59	

Average points per game (*for*), 10·75.
Average points per game (*against*), 9·15.

(We are indebted to Mr. R. C. Holloway for preparing these figures.)

Guy's Hospital Cricket Club

May	29th*	Stoics	H.O.P.
June	1st	Imperial College	H.O.P.
	8th	Beckenham	H.O.P.
	12th*	Guildford	H.O.P.
	15th	——	—
	22nd	Three Counties Hospital.	Arlesly (Beds.).
	29th	Malden Wanders'	Malden
July	6th	Old Olavians	H.O.P.
	13th	Finchley	H.O.P.
	20th	Honor Oak	H.O.P.
	27th	Chelmsford	Chelmsford
	31st*	Guildford	Guildford
Aug.	3rd	Orpington	Orpington
	10th } 17th }	TOUR, centred on Paignton, Devon.	
	24th	Honor Oak	Honor Oak
	31st	Beckenham	Beckenham
Sept.	7th	Public School Wanderers	Dulwich
	14th	Crofton Park	H.O.P.

Sunday Matches.

June	2nd	Finchley	Finchley
	9th	Woolwich Garris'n	Woolwich
	16th	Amersham	Amersham
	30th	Metropolitan Pol.	Imber Court
July	7th	Streatham	H.O.P.
	14th	Beddington	Beddington
	21st	Buccaneers	H.O.P.
	28th	Old Westminster Citizens	H.O.P.
Aug.	25th	Streatham	Streatham
Sept.	8th	Sutton	H.O.P.
	15th	Metropolitan Pol.	H.O.P.

* Wednesday matches.

Cricket

GUY'S *v.* PUBLIC SCHOOLS WANDERERS

(*Played at H.O.P. on Saturday, May 4th*, 1946.)

Won by 66 runs.

As the gentle but frigid zephyrs of spring drew the muttered imperative "Play" from the umpire's lips, Guy's, having lost the toss, found themselves batting. Against a medium attack two batsmen were out at 13, when Dyer joined Munro to make light of the bowling. Platt followed Dyer's 28 with a rapid 19, and Graham produced a strong 24. Throughout the innings Munro, at the other end, amassed a steadily increasing total which at the close represented 80 not out—an excellent performance without practice.

The opening ball of the Guy's attack deserves attention. Trist, bowling a very fast ball outside the off stump at "altitude eyebrow," had it placed full toss over the square leg boundary. The other bowlers, apart from Webb, could not even attain this degree of notoriety, but he managed to obtain five wickets, one due to a very fine catch by O'Driscoll in the deep for 23 runs on a comparatively dead wicket.

Team.—E. W. Graham (captain), J. D. Williams, L. D. Carton-Kelly, A. E. Trist, I. A. M. Munro, W. B. Webb, R. Harvard Davis, H. M. C. O'Driscoll, K. D. Allanby, H. E. G. Dyer, A. M. Platt.

Scores.—Guy's, 182 for five wickets, declared (Munro 80 not out); Public Schools Wanderers, 116 (Webb, five for 23).

GUY'S *v.* WESTCLIFFE-ON-SEA.

(*Played at Chalkwell Park on Saturday, May 11th*, 1946.)

Drawn.

Westcliffe air may be bracing to most, but in the first hour of play it reduced the Hospital bowlers to a state of complete inefficacy and its fielders to something several degrees worse.

As a result 90 was on the board before Carton-Kelly, who was treated throughout with the respect his steady bowling deserved, dismissed Turner for 35. His partner, Thornton, went on to make 70 followed by three players scoring 30 odd apiece to bring the total to 223 for six (declared). Webb, now acclimatised, bowled a second spell which produced three good wickets.

The late afternoon weather at Westcliffe stimulates Guy's batsmen. After two early losses Dyer, joining Munro for a third wicket partnership of 107 runs, started rather nervously, but settled down later to deal with the mediocre onslaught in the correct manner; the partnership broke when, in forcing the pace, Dyer was caught for 41.

Munro's innings of 115 not out in two hours left nothing to be desired as he showed us a degree of aggression hitherto unseen, cutting and driving so forcefully as to cause considerable manual discomfort to many a fielder. At the close Guy's were 36 runs behind with five wickets in hand.

Team.—E. W. Graham (captain), Williams, Carton-Kelly, Munro, Trist, Webb, Harvard Davis, Allanby, Dyer, Platt, P. S. Holmes.

Scores.—Westcliffe-on-Sea, 223 for six declared; Guy's, 187 for five (Munro, 115 not out; Dyer, 41.)

GUY'S *v.* ASHTEAD.

(*Played at Ashtead on Sunday, May 12th*, 1946.)

Won by three wickets.

Playing on a ground of considerable rural beauty Graham once again failed to judge the spin of the coin, so Guy's took the field. With Russell and Carton-Kelly bowling at the wrong ends and Trist three-quarters of the way to Brighton on the wrong train the bowling was none too strong, but Ashtead took little advantage of this. The two opening bowlers changing ends, a few overs by Dyer and the return of Trist from afar off, brought better results and Ashtead were half out for 58. Weller and James were the only batsmen to make progress, but when they were separated Russell was quick to dispense with the remainder, taking in all four for 26.

The Guy's innings started well with Harvard Davis returning to form and Munro continuing as from the previous day. At 90 Harvard Davis was out for 23, and a little later Munro was bowled for 41, giving him an average for the season of 236. With three wickets down Dyer went in, gave an admirable

imitation of a lacrosse player and soon came out. This, apparently, was the cue for other players to bat in a vein rather lighter than the situation demanded, so the Hospital had only three wickets in hand when the opposing total was passed.

Team.—E. W. Graham (captain), Williams, Carton-Kelly, Trist, Munro, Harvard Davis, Allanby, Dyer, Platt, G. P. Billingham, P. S. Russell.

Scores.—Guy's, 113 for seven (Munro, 41); Ashtead, 112 (Russell, four for 26).

Tennis Club

The Nursing Staff are invited to use the courts at H.O.P. on any weekday except Saturday. The invitation cannot be extended to week-ends because of Hospital matches. Six grass courts and one hard court are available.

A mixed American tournament is to be held on a forthcoming Sunday for staff, students and nurses. Further information can be obtained from the tennis notice-board in the Colonnade.

The team has played four matches so far this season and has won three and lost one.

P. J. DWYER,
Captain.

R. Freeman is captain of United Hospitals, whose team, containing four Guy's men, recently beat Cambridge University 8–1.

P. J. Dwyer is Captain of the London University team and has been awarded his Purple.

Hospital Information, etc.

Notices

GUY'S HOSPITAL DENTAL DEPARTMENT.

Applications are invited from gentlemen who have held the post of House Surgeon in the Orthodontic Department of a Teaching Hospital or other Institution specialising in Children's Dentistry for the posts of Orthodontic Assistant. Duties consist of the treatment of orthodontic patients under the supervision of the Dental Surgeon, Assistant Dental Surgeon and Registrars in the Children's Department. Attendance is on three sessions per week commencing on October 1st, 1946, and the appointment is for twelve months in the first instance. Honorarium is at the rate of £100 per annum.

Application forms, duly completed, should be sent before July 1st, 1946, to the Dean, Medical and Dental Schools, Guy's Hospital, S.E.1.

UNIVERSITY CANDIDATES AND THE FINAL L.R.C.P., M.R.C.S. EXAMINATION. JULY, 1946.

In view of representations which have been made by some Medical Schools on behalf of a considerable number of candidates who were unsuccessful in the recent Final M.B., B.S. examination, it has been decided as an exceptional measure to accept *provisional* entries for the Final L.R.C.P., M.R.C.S., examination, which begins on July 3rd, from such candidates. Their entries will be dependent upon the candidate passing in Part II of the First Examination (Pharmacology and Materia Medica) which begins on June 24th next.

Such entries can only be accepted under the following conditions, namely :—

1. The schedules for Part II of the First Examination and for the Final Examination must be submitted together, duly completed and signed in accordance with the regulations, accompanied by the necessary certificates of the Second M.B., Age and Vaccination, together with the fees for *both* examinations, not later than *Thursday, May 30th*, 1946. Evidence from the School will be required to the effect that the candidate was unsuccessful in the Final M.B., B.S. in April, 1946.

2. The formal receipt for the Final Examination fee will not be issued until after the result of Part II is known (not later than June 28th). If a candidate fails in Part II of the First Examination his fee for the Final examination will be returned in full.

3. These provisional entries will have to be added to the end of the examination lists for the Final examination, so that it will not be possible for such candidates to have early dates for completing the Final Examination.

4. These arrangements are without prejudice and must not be taken as a precedent.

HORACE H. REW,
Secretary,
Examining Board in England.

PUPILS' PHYSICAL SOCIETY.

TREASURER'S PRIZE ESSAY, 1946.

The subject for the Treasurer's Prize Essay this year is :—"The Importance of Psychological Factors in Organic Disease."

The prize (£5) is open to all members of the Physical Society, except qualified men of more than two years' standing at the date of the reading of the paper.

Essays must be delivered to the Honorary Secretaries by the 1st September, 1946.

Each essay must be distinguished by a motto or device, and accompanied by a sealed note, inscribed with the motto or device, and containing the author's name.

The prize essay will be read by the author, and discussed at a meeting of the Society during the 1946–47 Session.

J. R. FORBES,
J. E. SPALDING,
Hon. Secretaries.

GUY'S THEATRE CLUB.

"French Without Tears" will be produced in the Physiology Theatre on the following days :—

Wednesday, June 12th, at 7.45 p.m.
Thursday, June 13th, at 6.30 p.m.
Friday, June 14th, at 5.30 p.m.
Saturday, June 15th, at 2.30 p.m. and 7.45 p.m.

Admission, free of charge, by ticket only. All seats bookable.

Apply to : D. G. Chalmers, Guy's Hospital, S.E.1.

NOTICE.

The *Gazette* can now be bound at a cost of 7s. 6d. complete, or blue cloth binding cases (with crest on front board) are obtainable at 3s. 6d. each, post extra, from the *Gazette* Office, Guy's Hospital, S.E.1.

Deaths

COUNSELL.—On May 4th, 1946, at 2, Pusey Street, Oxford, after a short illness, Herbert Edward Counsell, F.R.C.S.

EDS. {J.M.H. R.H.N.L.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

THE "Passim" of four weeks ago has plainly stirred up, not strife—we cannot admit the intimation of one of our correspondents—but interest. Rightly or wrongly, the topic which it embraced had been causing unnecessary concern, for there seemed to be no sound motive for not bringing the whole matter out into the open. We welcome the correspondence. At the same time we are dismayed to learn that a number of students, fearful lest they might prejudice their position in the eyes of the authorities, do not care—do not dare, in fact—to enter into correspondence in the columns of the *Gazette*. This is a deplorable state of affairs for which there can surely be no basis. For one thing it betrays a timorous, servile and selfish attitude of mind; for another, it presupposes a want of integrity on the part of the authorities. A thorough ventilation of views is never undesirable. Not to admit this is to bow to imperiousness.

We are no less subject to criticism or approbation than are the Editors of any other journal. The business of being an Editor would lose much of its savour if we were. Our critics are plentiful and their criticisms diverse. We are often accused, for example, of lacking in initiative, and we shall have more to say about this later on. But first of all, "Passim"—the Editors' special prerogative and frequently the target for attack.

It is unreasonable to suggest that "Passim" can cover every aspect of Hospital life and every controversial problem. It does its best, but what is abhorrent to one is agreeable to another, even, perhaps, to the Editors. But our impartiality is such as to allow us to say that there is practically no limit to what can be discussed through the medium of the correspondence pages. As for "Passim" it is mainly a commentary on Hospital affairs; that it may happen to be provocative is coincidental or unavoidable. Further than this it would be presumptuous to postulate a policy.

Some people affirm that "Passim" invariably expresses a minority opinion, but an incident occurred recently upon which we feel bound to pass judgement, conscious of the overwhelming support, in this case, of a substantial majority. The incident itself is trivial; the tendency underlying it is alarming. A student came to consult a senior surgeon in one of the Out-patient departments. He strolled into the room smoking a cigarette. Not content with this, he talked to the surgeon with the cigarette drooping between his lips, so that a large quantity of smoke was puffed out into the surgeon's face. Such an exhibition of bad manners would be hard to emulate. There is a certain laxity in manners and dress in the Hospital to-day which is regrettable, but in tune, some would say, with the times. Conditions make the matter of dress exceptionally difficult, but there is no excuse for a complete absence of good manners. The remedy, of course, is an individual one.

Finally a word or two about the recurring complaint of our lack of initiative. We are occasionally asked, "Why didn't Mr. So-and-So's lecture appear in the *Gazette?*" More often than not the answer is, "Because Mr. So-and-So didn't wish it to appear." Requests for articles (of a serious or amusing but essentially appropriate nature) and for drawings, cartoons and verse have repeatedly, in the past, been made in these pages. A personal or written approach has often been adopted. The response is seldom satisfactory, and once again we reiterate the previous appeals. We shall always be glad to receive reports from ward-clerks and dressers of the more interesting cases in the wards. At one time these reports were a feature of the *Gazette*; although we hesitate to revive old customs uncritically, we feel that this is one worthy of revival. Limitation of space does not preclude the serious consideration of any material submitted.

WE offer our very good wishes to Mr. Michael Hall on his retirement as Editor of the *Gazette*. At a recent meeting of the *Gazette* committee, Mr. John Blundell was appointed the new Assistant Editor.

Congenital Heart Disease

By MAURICE CAMPBELL, O.B.E., M.D., F.R.C.P.,
Physician and Physician-in-Charge, Cardiographic Department, Guy's Hospital,

A Lecture delivered at Guy's Hospital on Friday, January 25th, 1946.

GENTLEMEN,—Sometimes this seems a dull subject because of the lack of treatment for the condition, so that there is a feeling that it does not much matter about the diagnosis. There are two reasons why I think it is of great importance. The management of the patient, with advice as to how much he should do, and the prognosis are very important sides of treatment in heart disease, and patients and the parents will be extremely anxious to have that advice and prognosis from you. Secondly, you cannot make a correct diagnosis in heart disease unless you know what all the possibilities are, and unless you are familiar with the signs of congenital heart disease you will mistake some of these cases for other types of disease and treat them wrongly. In recent years a third reason has been added to these two, in that treatment is becoming increasingly important. One form of heart disease, patent ductus arteriosus, has been successfully subjected to surgical treatment in a large number of cases, and only yesterday Dr. Crafoord, of Sweden, was speaking in this country about his operation for coarctation of the aorta. Thus the lack of interest on the ground thet there is no treatment is to some extent disappearing.

I am not going to discuss the embryological causes. It is a complicated subject and the more serious congenital abnormalities are, on the whole, incompatible with long life, and are of interest to the embryologist rather than to the clinician. Roughly speaking, a number of these specimens which are on the table before you are the small hearts of fœtuses or of children who died almost at once, while the others are of larger size and are the hearts of adults. The small hearts present mostly a number of abnormalities and are not of clinical importance ; the others, on the whole, are picked out as instances of single abnormalities which have been consistent with reasonably long life and are of clinical importance. The list which I show below may appear quite formidable. I have divided the conditions into three groups. In the first there is no connection between the right and left side of the heart, and there is no cyanosis at the start nor any possibility of developing it. In the second group there is some connection between the left and right side of the heart, but, on the whole, the pressure on the left side is higher than on the right, and therefore blood will generally go from the left side to the right, and there will be no cyanosis, but the fact that blood is going from the left side to the right for many years may gradually raise the pressure on the right side of the heart, and finally the pressures may become equal, or the pressure on the right may become even greater than on the left, so that venous blood may start mixing with the aerated arterial blood and cyanosis may develop. The second group therefore do not as a rule have cyanosis, but may develop it later in life, though practically atrial septal defect is the only one where this happens at all frequently. The third group have striking cyanosis from the start, because, although again it is equally true that the pressure is greater on the left side than on the right, the opening between the two sides is so large that there is mixing of blood ; or from pulmonary stasis in pure pulmonary stenosis. Therefore, in this third group, cyanosis is an important factor.

CLASSIFICATION OF CONGENITAL HEART DISEASE.

I. Without cyanosis. With no shunt between the right and left sides of the circulation.

Dextrocardia,
Congenital Complete Heart Block,
Sub-aortic Stenosis,†
Bicuspid Aortic valves,
Coarctation of Aorta.†

II. Without cyanosis, except later (cyanose tardive) or perhaps terminally. With a shunt, generally from the left to the right side, but sometimes reversible.

Patent Foramen Ovale,
Auricular Septal Defect,*
Maladie de Roger (small localised ventricular septal defect),
Patent Ductus Arteriosus.

III. With cyanosis. With a shunt allowing venous blood to mix with the arterial (except in the case of pure pulmonary stenosis),

*Pulmonary Stenosis (a) and Atresia,**
Ventricular Septal Defect (*b*),*
Fallot's Tetrad ((*a*) and (*b*) combined).*

† Electrocardogram may show left ventricular preponderance.

* Electrocardiogram generally show right ventricular preponderance.

I shall spend most of my time going through these separate conditions, but I should like to take one or two general matters first. You are all familiar with the picture of congenital heart disease with gross cyanosis. The patient is short of breath ; there is polycythemia ; the hæmoglobin may be up to 150 per cent and the red count to seven or eight million ; and there may be striking clubbing of the fingers. In that extreme form the patient is very limited in his capacity, and possibly the exact diagnosis of his condition is not of the greatest importance. I can speak rather more shortly of this last group, therefore, than of the earlier ones in which cyanosis is not an important feature. When you see a child soon after birth the diagnosis of the form of the congenital heart disease is often extremely difficult, and I would give you two warnings in dealing with prognosis. If cyanosis, due to congenital heart disease, is recognisable at all in the first weeks of life, however slight it may be, it is likely to become more severe as the child grows up and to bring the child into this last category. Therefore, a slight degree of cyanosis which in an adult you would describe as of relatively little prognostic significance must be taken much more cautiously in a child, because it is going to increase. The second point is that it is difficult to say that the heart is not greatly enlarged in small children. You will often find when you X-ray a child with congenital heart disease that the heart turns out to be much larger than you had thought clinically. For both these reasons, although I am an optimist in prognosis, and very keen that you should be as optimistic as you reasonably can, you do want to be cautious in your opinion about congenital heart disease in small children.

Dextrocardia.—After these general remarks I can now go on to the different conditions I want to talk about. The first on the list is dextrocardia, which is found in two forms. In one the heart is on the right instead of the left, and all the other viscera are transposed as well, so that the body is simply a mirror image of what it ought to be. In the other form the heart is on the right side of the thorax, but the other viscera are in their normal position. The first of these forms is the commoner and is, I think, of no importance. A patient can work and lead a normal life with all his viscera on the right instead of on the left, and it does not appear to lead to any disability, except that some people have suggested that bronchiectasis is more common in these cases ; possibly the unusual pressure on the right lung—this being less adapted to the heart being moved over to that side—may be a factor. The electrocardiogram is almost as decisive for diagnosis as the X-ray, all the excursions in lead 1 being reversed. When the heart is on the right instead of on the left and the other viscera are in their normal position, it is generally or often found that there are other congenital abnormalities as well. Therefore these cases of dextrocardia, though they do not matter in themselves, do need a careful search for other forms of heart disease ; they may also have congenital malformations elsewhere.

Congenital Heart Block comes next on the list. This is not extremely common, but it is commoner than is always recognised, because the heart rate is not nearly as slow as in acquired heart block, and therefore such cases may be missed. The block is generally complete. I remember a dental student whom I have seen for a good many years with the diagnosis of congenital complete heart block since he was referred for an electrocardiogram for life insurance. While a student he had been a patient in Guy's with jaundice and had been demonstrated as a case of bradycardia due to jaundice, showing that it is not the slow rate of 28 or 30 found in acquired heart block, but very often 50 or 56. Another of my congenital complete heart block cases, with whom I have been in touch for many years, has been in the Air Force throughout the War and was passed as fit for flying duties. Congenital complete heart block is not often associated with Stokes-Adams' disease and is, on the whole, a condition with

very good prognosis. I wrote an account twelve years ago of eight cases I had seen up to then. I managed to trace all those eight cases during the War, and, on the whole, they have done extremely well. There has been no serious episode except that in one case tuberculosis has developed. They are all at work, some of them pretty actively. I think that as people get more familiar with this condition we shall find that among some of the elderly heart blocks there are really a few who have had the condition all their lives and are congenital cases. At the moment the oldest I know is about forty-eight, but I do not see any reason why that one and some of the others who are in their thirties should not live a long time. The first two conditions set out here, then, are compatible with long active lives and are really important only from the point of view of diagnosis.

Sub-aortic Stenosis is the next on the list, and that is not very rare. If you find signs in a young patient suggesting aortic stenosis, and the patient is relatively fit, you should think of the possibility of it being congenital. The physical signs are just the same as those in acquired stenosis. One uses the term "sub-aortic stenosis" because the stenosis is not actually at the site of the valves but just below that, due to a developmental abnormality in the heart. The young patient who gets rheumatic aortic stenosis will generally have had a very severe attack for aortic stenosis to develop while he is still young, and therefore you will find the other signs of severe rheumatic infection—a large heart, considerable dyspnœa, and almost certainly mitral stenosis—but these congenital cases may have the same degree of aortic stenosis with a normal heart muscle; there is no other disability, and therefore they ought to be very well. I remember one small boy who had won all the races in his school sports without any particular symptoms coming to me with striking signs of aortic stenosis. Again, the centre forward of one of the well-known professional Soccer teams in London a few years ago also had congenital aortic stenosis. Therefore this is compatible with a considerable degree of activity, though it must limit the work of the heart and make the patient more breathless than he would be without it.

Bicuspid Aortic Valves cannot be diagnosed directly. It is quite a common finding to have two cusps instead of three for the aortic valve, and although you do get anomalies in the number of cusps of the other valves, none of the others occur so frequently or are of such importance. Occasionally one finds four cusps on the aortic valves and sometimes abnormal numbers on other valves. It shows the difficulties there are in clinical medicine of drawing deductions from reasonable physiological and pathological facts, because I think anyone might guess that if you have two cusps instead of three a certain number of cases will develop aortic regurgitation, and therefore bicuspid aortic valves might be diagnosable by that. It is so rare that for practical purposes it may be said that it does not occur, and bicuspid valves would be unimportant but for two reasons. The first is that they are particularly prone to infective endocarditis and the extra stress and strain in that area with two valves instead of three leads to the development of atheroma in the valves and surrounding parts of the aorta at an unusually early age; one may find patients at the age of thirty with atheroma such as is seen in a man of sixty. When either of these things happens aortic incompetence often develops, so when you see an unusual case of aortic incompetence you should think that one of these things has happened to congenital bicuspid valves.

The occurrence of infective endocarditis on these valves is interesting, and proves, I think, that all of us, whether we have two cusps or three, are prone to get bacteræmia from time to time. The normal valves, however, do not provide a suitable place for the bacteria to settle on, but if there are two valves instead of three it constitutes a weak spot which allows the bacteria to settle and so leads to the development of infective endocarditis.

If you find a case of infective endocarditis affecting the aortic valves alone in a patient without a rheumatic history, you will be making a fairly safe guess in your diagnosis of congenital bicuspid aortic valves as the cause of it. Often one may notice that, in addition to having two cusps instead of three, there is a firm ring matting two of them together which looks rather like, and sometimes has been mistaken for, an inflammatory mass, but really it is part of the congenital condition.

Coarctation of the Aorta is the last of the conditions with no tendency to cyanosis; perhaps the most important of these and the commonest is coarctation of the aorta. Coarctation simply means narrowing. It may include narrowing up to the point of complete obliteration, and the narrowing of the aorta occurs near the point where the ductus arteriosus joins the pulmonary artery and the aorta. In some cases the ductus

remains patent, in other cases it is closed, so that one has a coarctation alone or a coarctation associated with a patent ductus arteriosus. The collateral circulation is often less well developed when the ductus arteriosus remains patent. It is surprising what high grades of narrowing of the aorta may be compatible with a reasonably good circulation, and sometimes the obstruction is complete and the circulation entirely dependent on the collateral circulation.

It is one of the most striking of all illustrations in medicine of the development of the collateral circulation. One notices the visible arteries on the front of the chest just from the anastomosis between the internal mammary and the epigastric artery and the anastomosis all round the scapula, so that one may also find these large pulsating arteries at the back, and the intercostal arteries also take part in the anastomosis so that they may become large enough to show notching on the ribs under the X-rays. I will pass round one or two photographs which will show you the main points where the collateral circulation may develop, and some X-ray pictures of the injection of the collateral circulation.

Physical signs that may lead you to a diagnosis of coarctation may be these dilated arteries on the back or on the chest where the collateral circulation has developed. Other physical signs may be again those of aortic stenosis, although, of course, the narrowing is further round the aorta and nearer the position at which one might expect to diagnose pulmonary stenosis. On the whole, the physical signs will be very much those of an aortic stenosis combined with the other features.

An important physical sign is the high blood pressure in the arms without any increase in the legs. One may get a blood pressure of 200 in the arms in quite young patients. One of the most interesting cases of that kind which some of you may have seen in the wards about six months ago was a woman in her third pregnancy. I saw her first, I think, about eighteen years ago and I did not diagnose her condition correctly. It was in her first pregnancy when she was in her twenties and I found a very high blood pressure, and thought this was due to the effect of pregnancy on her kidneys, and that she had a relatively bad prognosis and should have no more children. Two years later, however, she came along in a second pregnancy ; her condition showed no deterioration, and either because the collateral circulation had developed in that period or because I had learned more about coarctation, I was able to make a correct diagnosis. She had a good collateral circulation then, with notching of the ribs, and therefore one could give her a much better prognosis than one would have done had that increased blood pressure been due to renal disease. I saw her for a time after that and then heard no more about her until two years ago. She had in the meantime left London. Then last year she came back with a third pregnancy. She had a larger heart, a higher blood pressure, and an even more striking collateral circulation, but, on the whole, she had relatively few symptoms, and felt fit in spite of the high blood pressure. Obviously with a blood pressure as high as that since she was in the twenties and possibly since she was seven or eight years old, her prognosis is a serious one. It has put a great deal of extra strain on her heart, and although one might suppose that with a patient who has done so well the lesion is not too serious, the outlook for her is not good, in view of the fact that she has had that high blood pressure for such a long period.

On the other hand, it has been recognised from quite early times that some patients with coarctation of the aorta do develop such a good collateral circulation without much rise of pressure that they may live to a good age. Patients have been described in the seventies and eighties. Another patient I remember came to the Out-patients' complaining of rheumatism ; he was working as a gardener ; and we were so interested in finding that he had coarctation of the aorta that he felt we did not pay enough attention to his rheumatism, and would not come to hospital again.

In some cases the large vessels are big enough to produce pressure on the nerves and may cause very obscure pains in that way, but as this man's pains were mostly in the legs I do not think that was the cause in his case. It is not a rare condition. I once had two small boys of about twelve who were in beds next to each other. One had obvious coarctation of the aorta, and Dr. Suzman, my clinical assistant, wanted to make the same diagnosis in the other. I was more hesitant, but the course of events showed that it was so, and as he has grown up he has developed a more obvious collateral circulation.

You may wonder why I speak of the collateral circulation developing in this way and you may feel that if this is a congenital lesion the collateral circulation ought to appear just as much at the start as it does later on. But there are changes in the relative

importance of congenital lesions, and I think that what happens in most cases of coarctation is that the coarctation does not keep pace with the growth of the child as a whole. The aorta will grow but the coarctation will remain the same and therefore will become of relatively much more importance. In some parts of the heart that same position leads to an improving state of affairs. Let us suppose that we have a small opening between the right and left ventricles. As the heart grows larger and the opening remains the same the lesion will become of less importance as the child grows older, instead of becoming of more importance as it does in coarctation. Therefore, one can account for some changes in the course of growth even in these congenital lesions.

I do not know about the details of the operation that is proposed for this condition, but it consists of the removal of the constricted portion with an anastomosis. It is clearly a very serious procedure, but it has been successful experimentally in animals and some patients have had the operation and survived. It will need very careful consideration of what the risks are in any particular patient and what the prognosis is, but the fact that these operations are becoming possible means that it is necessary for everybody to be very much more interested in congenital heart disease and to learn more about the nature of the prognosis and the risks, so that we may be in a better position to assess in a particular case whether it is worth while subjecting a patient to that risk.

Patent Foramen Ovale.—The next group we come to are cases which start without cyanosis, but may develop it. We come to the two most common of all congenital conditions in this group. On the list before you I have put patent foramen ovale in brackets, because clinically it really hardly matters. It is a small opening between the right and left auricles, and it is present in about 25 per cent of cases examined post-mortem. In a great many cases there is a small flap over the opening which may act as a valve and prevent the blood going from one side to the other. But even when the flap is not a complete closure—and a good many cases will be seen in the post-mortem room where there is an opening which will just about take the point of a pencil—the amount of blood that goes through it is of small importance. Thus it is a lesion which is of interest to the pathologist rather than to the clinician. It may occasionally give rise to a systolic murmur over the base of the heart and, if the opening is big enough, it is responsible for one very odd and interesting clinical phenomenon, what is called " paradoxical embolism." One would think from the source of the clot that the patient ought to be getting a cerebral or peripheral embolism, but, in fact, he gets a pulmonary embolism. The clot has passed through from the left to the right auricle and so affects the other side of the circulation and, in these cases, if there is mitral stenosis and a clot in the left auricle, there may be a pulmonary instead of a cerebral embolism.

Maladie de Roger.—For the second condition in this group, I have given it the original French name because the English name is long—a small localised defect in the septum ventriculorum. It always occurs in the same place, just under the valves. The flow of blood through that opening is enough to give quite a loud systolic murmur and often a thrill. A great many of these cases are diagnosable with reasonable certainty because the systolic murmur is loudest at the point where none of the ordinary systolic murmurs are heard, rather low near the mid-sternal line, well away from the mitral or the aortic areas. A rough systolic murmur at that point which may be associated with a thrill is fairly diagnostic of that condition.

Anyone who has experience of congenital heart disease from examining routine patients in school clinics realises that this is the commonest of all congenital heart diseases, and, fortunately, in most cases it is unimportant because, as a rule, that opening is small, and, therefore, although the murmur is loud, the amount of blood passing through does not have much effect. It is very uncommon for this to be enough to raise the pressure on the right side of the heart and lead to the development of cyanosis later on.

Auricular Septal Defect.—You may wonder that I separate this condition from patent foramen ovale, which is a defect in the auricular septum. The larger defects in the auricular septum arise at a different point and have a different embryological origin, but the clinical reason for separating it is that the patent foramen ovale is nearly always a small opening and the other is an opening of considerable size and of great importance, and the patients with it do more than any other group develop cyanosis as life goes on. They may not be diagnosed as having congenital heart disease until they are twenty or thirty, and then they develop cyanosis and the X-ray changes may show quite unmistakably that that is the type of case with which one is

dealing. This condition is more common in women than in men, while, as a contrast to that, most of the conditions associated with aortic abnormalities—aortic stenosis, bicuspid aortic valves and coarctation—are all more common in men than in women. Nobody has suggested any reason for that difference, but in auricular septal defect the proportion is four to one in women.

The condition is most likely to be suspected on the patient becoming cyanosed relatively late in life. Physical signs will not lead one very far although he will often get systolic murmur at the base of the heart and may have a thrill. If the opening is too large one may get no murmur at that site, but there is often an associated dilatation of the pulmonary artery from increased pressure on the right side and that may give a systolic murmur and sometimes a thrill over the pulmonary artery. When once suspected the settlement of the diagnosis depends mainly on the X-ray appearances of the heart, because we find a heart in which the right ventricle comes to occupy an unusually large part of the heart, and with enormous dilation of the pulmonary artery and of all the pulmonary vessels. If one is looking at the patient on the X-ray screen one may see what is called a " hilar dance " ; it is really like the sudden jerking with which one is familiar in aortic incompetence, but is due to the blood coming out of the lung roots so that they show up suddenly and fade away again as in capillary pulsation. The X-ray picture will clinch the diagnosis. An electrocardiogram will also help by showing right ventricular preponderance. There is one other point that is interesting and odd about this group of cases. It is the only congenital abnormality in which auricular fibrillation is at all common. Whether this is entirely because a lot of these patients get mitral stenosis as well (Lutembacher's disease) or whether it is due to other reasons is uncertain. The commonest thing is to find a patient with this condition plus mitral stenosis plus auricular fibrillation, but others are found who have auricular septal defect with fibrillation without mitral stenosis, and it is very rare to find fibrillation with any other congenital heart disease.

Patent Ductus Arteriosus is one of the most important of all the congenital lesions with which you should keep in touch. This is because of the important work that has been done on the surgery of this condition, and it is probable that all of you will come across cases when you have to consider whether you are going to leave the congenital defect alone or get further advice about the possibility of its surgical treatment. The murmur here is quite unlike any other murmur. A few years ago a student in the Conjoint examination had the courage to say that the murmur was " unlike anything I have heard before ; therefore the patient has patent ductus arteriosus."

The murmur goes the whole way through systole and diastole. It must, because if there is communication between the aorta and pulmonary artery there must be a constant blood flow throughout the whole of the heart cycle, and it will not vary much at different stages. The drop between the diastolic and systolic pressure in the aorta will not be enough to influence greatly the degree of flow. The diagnosis therefore is usually relatively simple in this case. The fact that blood flows from the aorta to the pulmonary artery may lead to a rather low systolic pressure ; in other cases it has the same effect on aortic incompetence and one gets a wide pulse pressure. If you give a patient exercise you can generally bring out this high pulse pressure if it is not already present and get additional confirmation of the diagnosis in that way. There is nearly always a thrill associated with the murmur, the thrill lasting through systole and diastole as well, so that that also helps in the diagnosis.

The first thing that anyone will reasonably ask in considering operative treatment for these cases is as to the prognosis, and it is unfortunate that we have not followed up these congenital cases with the care we ought to have done. I cannot refer to any large series which has been followed up by anyone throughout life, but it has been talked of a great deal amongst cardiologists recently and they do all agree that it is rare to see a patient with patent ductus arteriosus after the age of forty, so that it looks as if the ultimate prognosis was not very good.

We have been familiar with the fact that a proportion of these people die with infective endocarditis. But beyond that it is not common to see patients dying with patent ductus arteriosus or heart failure or any other condition, and it is rather mystery what happens to them. It has raised the question whether the patent ductus becomes closed and ceases to matter in a proportion of cases. That is well known to happen, and there are cases on record where a patient has been observed with this loud, striking murmur and a year or two later has been seen without it. In more recent cases the improvement in the X-ray picture has also been seen, so that one is certain that some of these cases cure themselves spontaneously. Nevertheless, I think

that that is not likely with many of them, for it is such a striking episode that those who see it would be likely to put their cases on record, and the records are not many. Therefore, we must take it that the natural outlook for patent ductus arteriosus carries a considerable risk of death at some time before the age of forty.

The operation is simple theoretically; it is only a question of the practical difficulties of the site and of an effective ligature, and if this communication between the aorta and the pulmonary is tied the patients should revert to their normal condition, and in fact they do. The heart is found to diminish in size, the pulmonary artery which has been distended diminishes in size and the patient returns to a normal condition. Apart from the risks of such a serious operation, even in very expert hands, there is the great drawback that in a small number of cases the aorta and pulmonary artery will be found so close togather that there is no ductus arteriosus, but only an opening between the two which are well fixed together, and the surgeon will not be able to deal with that. Therefore one cannot be quite certain in every case that it is going to be possible for the surgeon to do something.

In the successful cases there will be a real duct which can be tied. It is quite difficult to tie the duct effectively and several cases which have been tied have opened up again, but that will probably be overcome with different materials and greater experience. It is even more certain if the ductus be cut and ligatured at both ends, but this is technically more difficult. Therefore, although successful in a large number of cases, the operation is not one to be embarked upon lightly.

One cannot wait indefinitely to make up one's mind on this matter because, on the whole, a patient up to the age of sixteen is a much lesser operative risk than one who is older. Therefore, on the whole, it is a thing which must be done before the age of twenty if at all, though it is true that older cases have been operated upon. The surprising thing is that that operation has cured cases with infective endocarditis. It is common now to find cases of infective endocarditis which are cured with penicillin, but in the past the treatment, even with the sulphonamides, has been most disappointing. Many things have been tried in the last twenty years, but they have all turned out unsatisfactory and, practically speaking, all cases have died. It is amazing that a surgical procedure should have been the first to cure cases of infective endocarditis. The body, when it gets the circulation back to normal, seems from that point to be able to deal with the infection, and things quickly settle down. Quite a number of these cases have been cured by operative treatment.

Pulmonary Stenosis and Fallot's Tetrad.—I do not intend to say much about the last group on my list, because they are the grossly cyanosed cases for which not much in the way of treatment can be done beyond controlling the activities of the patient, and my time is nearly up. I will only say that if a patient has gross cyanosis and has had it all his life it is almost certain that he is one of those who come in this third group placed in front of you. If he has a systolic murmur in the pulmonary area and a thrill he has pulmonary stenosis with or without the defect of the ventricular septum. If his heart is not very large and his condition fairly satisfactory he probably has pulmonary stenosis alone, and if he is very cyanosed he probably has it combined with the defect of the ventricular system. The term Fallots tetrad has become very well known in recent years for the combination, the third and fourth being the dextroposition of the aorta, and the hypertrophy of the right side of the heart. I have not talked about dextro-position of the aorta because, although it sometimes helps in X-ray diagnosis, it is not of much clinical importance. The right ventricular hypertrophy is really an illogical fourth because it is a development of the other three.

You may wonder why a patient with pulmonary stenosis alone should have cyanosis because there is no mixing of the blood of the right and left sides of the heart. The reason is that the condition produces so much stasis in the lung (and there is often dilatation beyond the stenosis—not behind it), so that a large amount of the blood passing through the lung cannot get oxygenated there. As a purely theoretical point, the cyanosis of pulmonary stenosis can often be abolished temporarily by giving the patient oxygen to breathe, because in that way the oxygenation is improved. I have already mentioned the clinical picture found in these patients, with gross cyanosis, polycythæmia, and clubbing of the fingers. On the whole, the prognosis is not good and they should lead a sheltered life though they are often able to work. Occasionally they do surprisingly well, and I remember one man in his thirties whom I saw from time to time for some years who was regularly working as a furniture remover and refused to make any change in his work.

Fox Photos Ltd.

H.R.H. THE DUCHESS OF KENT LEAVING HUNT'S HOUSE DURING HER RECENT VISIT

Obituary

HERBERT EDWARD COUNSELL, M.A., F.R.C.S.

DR. H. E. COUNSELL, who died on May 4th, 1946, at the age of eighty-three, was one of Oxford's most widely known and best loved doctors. For many years he had occupied a unique position in the life of both University and City, being affectionately known as "Doggins" to several generations of undergraduates and countless friends everywhere. Many will recall now the genial host of 37, Broad Street, the witty story-teller, ever popular prompter of the O.U.D.S., and kind friend whose wise advice and help was sought by everyone, and never in vain. He was, however, more than that; it is as a doctor that he will be most gratefully remembered in Oxford, both as a general practitioner and as medical officer to the Post Office Staff. In a preface to his memoirs—*Thirty-seven The Broad*—which he wrote in 1943 when blind and nearly eighty, Lord Nuffield rightly reminded his readers that "the number of benefactors who have given more practical help to the sick and suffering than has H. E. Counsell must be small indeed."

A student at Guy's in the 'eighties, when he "came in contact with the brilliant teaching staff of the Hospital—Dr. Hilton Fagge, Sir James Goodhart, Mr. Howse, Mr. Jacobson," Counsell took his F.R.C.S. in 1892. He was then in private practice at Liss in Hampshire, and the ten years he passed there as a country doctor strongly influenced his medical character, though the remaining thirty-five years of his active life were spent in Oxford. A fine surgeon, he was content to be a general practitioner; and many would say that as such he did more good and gave more generously of his talents than if he had sought greater distinction in his profession. As such he certainly became the beloved physician, being valued friend besides doctor to all his patients.

To a rare extent he represented that ideal " G.P." to whom patients are quite as much human beings to be helped in all their difficulties as medical cases to be cured of actual diseases.

Moreover, it enabled him to develop to the full his many-sided personality and varied interests, including history, in which he took an Honours Degree despite all his medical work, European travel and the theatre. Behind the scenes " Doggins " played a part which makes all members of the O.U.D.S. for ever indebted to him. And having helped so much to restart the Society after the First World War, he recently assisted in preparations for its curtain rising once more. In the thoughts of many, then, a well-remembered figure will be in the prompt corner.

But those who would take the full measure of a remarkable character should have had the privilege of knowing him intimately of recent years, when he faced blindness and infirmity with such courage. All that was most lovable in Dr. Counsell then became intensified—his sense of fun, roguish humour, gusto for life and interest in all its most human aspects, tolerance of everything except folly and cruelty, his gentle kindliness, courtly manner and strength of spirit. In his last act a fine English gentleman, who had ennobled many scenes in the theatre of life, played his greatest part.

H. B.

Correspondence

SIR,—Many kind people have written appreciative and affectionate words about me in your last issue, and I have had so many letters of good wishes and farewell from Guy's friends that my heart has been warmed, and I have been cheered on my rather uncertain way as I step out of the world of active employment, and join the ranks of the retired brigade.

The kindness of my friends has touched me very much and, through the medium of the *Gazette*, I send them my thanks. One never really says good-bye to Guy's; one's interest and affection for the Hospital last through life. My gratitude to all my colleagues and friends who have helped me in my work at Guy's during these many years is difficult to express in words, but will always remain with me.

Believe me, yours truly,

EMILY E. P. MACMANUS.

The Cottage,
Cassington, nr. Eynsham,
Oxon.

House Appointments

SIR,—The views expressed on the subject of house appointments in " Passim " in your issue dated May 11th, 1946, give a somewhat incomplete and inaccurate picture of the situation.

The reader unacquainted with the facts would assume from reading " Passim " that newly-qualified men now have to enter the Services without doing a house-appointment of any sort. This, of course, is completely untrue. Both in peace-time and during the war only a very small minority of those who qualified at Guy's obtained house-appointments at their parent Hospital. At the present time, as throughout the war, there have been more posts available in the Guy's sector hospitals than there are newly-qualified men with satisfactory records to fill them.

You ask in " Passim " for a statement of policy. Surely the policy on this matter was promulgated by the Government over a year ago. The Cabinet then decided that all medical officers, who were recently qualified when they joined the Services, should have an opportunity of holding a six-month house-appointment on their release. The Hospital has done its best to implement the Government's policy by doubling all the house-appointments.

Few will agree with the statement in " Passim " that the freshly qualified man is more fully equipped to undertake house-appointments than are those who have had many years' experience in the Services. If indeed the contention in " Passim " is correct—which it certainly is not—it would be an additional argument for giving house-appointments to all ex-service medical officers.

Fortunately there have been the most happy relations between those who have returned from the Services and present day students and recently qualified men. It is to be hoped that the *Gazette* will not pursue a policy of trying to stir up strife.

Yours, etc.,

J. J. CONYBEARE.

Guy's Hospital, S.E.1.

SIR,—The *Gazette*, in its editorial article about ex-service House Officers, has presented a picture which is not quite correct. On May 1st, 1946, appointments were made by the Medical Committee to sixty-four vacancies at Guy's and in Sector X. Of this number twenty-seven appointments went to ex-service men. It is true that the bulk of appointments at Guy's itself went to ex-service men ; fourteen appointments to ex-service men as against six to men who have not yet served. Some of the fourteen appointments would not have been made as separate appointments were they not to be held by ex-service men, but would have been held conjointly with some other appointment. Out of all those who applied, only eight men failed to get appointments. These will, of course, be eligible for appointments at other hospitals before going into the Services.

The ex-service men who at present hold appointments are derived from fifty or more release groups, so that it is unlikely that the percentage will ever be higher than it is at present. It is appreciated that the times are difficult for the newly qualified man but not so difficult for him as for the man who has already spent many years in the Forces, and such disadvantages as there may be should be accepted by the newly qualified man as another of the disabilities caused by six years of war.

Yours, etc.,

E. R. BOLAND.

Medical School,
Guy's Hospital, S.E.1.

SIR,—The *Gazette* is, I understand, what might be termed an independent journal : whilst it owes allegiance to the parent hospital, the views it expresses are not official, but those of its Editors. Furthermore, part of its columns are set aside for the sane and balanced discussion of some of the more important aspects of hospital life. I hope, therefore, that these columns will not be disturbed by acrimonious and irresponsible letters following your " Passim " of May 11th, 1946, in which you quite rightly discussed that increasingly important subject of the day—namely, house appointments.

The Hospital and Medical School has, in response to Government appeal, thrown open a number of house jobs to ex-service men, but unfortunately no statement as to the relative percentages available to these and to recently qualified men has been forthcoming. If the "doubling of appointments" is the policy, then there should be equal numbers for both. At the moment, amongst House Officers in the wards, the numbers are approximately sixteen against two, and not nine and nine. The newly-qualified man, not unnaturally, eyes the future in a similar manner to anyone else, and much of his apprehension might be removed if he were informed that he will have the opportunity of a house appointment in three years' time, as demobilised men have now.

For the present Guy's is catering for a very large number of post-graduates in addition to a greater number of undergraduates than were studying under its wing pre-war. Conditions are extraordinarily difficult ; students of all types in the wards must outnumber patients by about two to one. Amongst this slowly settling confusion, let us not forget that the vast majority of recently qualified men are guilty of only one crime : they were born too late. Nevertheless, they will be demobilised on the day after to-morrow. Let us hope that Guy's will treat them as it is now treating its older sons.

Yours, etc.,

K. D. ALLANBY.

Guy's Hospital, S.E.1.

SIR,—It is charitable to assume that "Passim" of May 11th, 1946, represented a naive and biassed aspect of student opinion. Its categorical answer may be left to an impartial authority, but meanwhile the editorial spokesman of one point of view might do worse than study the other before glibly prescribing an unsuitable remedy.

Ex-service doctors are able to decide for themselves the type of rehabilitation most suited to their requirements; moreover, the Medical Committee are presumably no less able to decide who among the various candidates for house jobs are most suited to perform them. Those among the recently qualified who view with dismay, perhaps even resentment, the increased competition offered by the candidature of ex-service men must not forget that even with the present proportion of ex-service appointments, the total number of jobs available to newly qualified men still exceeds the total number available before the War. At the same time, the ex-service candidates deeply appreciate the opportunity afforded them by their own hospital to apply for the job of their choice in open competition.

Goodwill is required on both sides: but if the author of "Passim" seriously believes that six years' experience in a fighting Service in time of war incapacitates a doctor both in his relationship with the nursing and teaching staff, and in the performance of the duties of his appointment, we for our part need not allow the presumptuous immaturity of this opinion to prejudice our relations with our younger colleagues.

I am, Sir,

D. STAFFORD-CLARK.

Guy's Hospital, S.E.1.

SIR,—Thank you for your recent "Passim" in which you wrote of the appointment of House Officers, a subject of as much interest to senior students as the planned National Health Service. That we have been roused is not surprising because the feeling is bound up with our first desire to study at Guy's, which had two sources:—(1) a doctor trained at Guy's can offer his patients a knowledge of the Guy's staff and the possibility of a bed under their care; (2) a doctor is respected for his education at a famous institution.

We have learned that some of each batch of students are given the honour of a house appointment in Guy's, which carries with it far greater opportunities for understanding and becoming acquainted with the staff and far more status in the eyes of medical men than the student achieves. In fact, exactly as we once wanted to become Guy's students, so we now are eager to be Guy's House Officers, and we are uneasy because the Medical School has given no promise to continue its present distribution of appointments until the release of the last medical man to be called up. We expect that the elect among our batches will duly be awarded the coveted appointments sooner or later, but we should appreciate a promise from the Medical School.

So much for the adaptation of the individual to the existing plan, but that plan is not perfect. Of the present ex-servicemen who are House Officers some were given Guy's appointments before joining the Forces; others were considered unsuitable. The former gain little now towards their efficient treatment of the patients in their future practice, or to their prestige by a job at Guy's rather than elsewhere. That the latter should be appointed represents inconsistency by the Medical School. The rehabilitation of these men and of my contemporaries, when they reach the same position, can be thoroughly performed by a period of attending teaching rounds and out-patients at Guy's, followed by an appointment at a non-teaching hospital. We, who are to be the ex-servicemen of the future, would profit more by the chance of a Guy's appointment in continuity with our student days than by the chance of one after military service.

Above all, whatever may be the plans of our superiors, let us be told.

I am, Sir,

H. W. TRUSTED.

Guy's Hospital, S.E.1.

Sport

Cricket

GUY'S *v.* OLD WHITGIFTIANS.

(*Played at H.O.P. on Saturday, May* 18th.)

Won by 48 runs.

On a wet wicket which he surmised correctly would later turn difficult, Graham elected to bat. Munro helped Harvard Davis to bring the score to 31 before he was caught at the wicket for 18, after which Graham and Williams followed with 21 apiece. Harvard Davis, who was out for 40, batted well, starting with eleven singles, but later, opening up, drove hard to gain runs in the cover country. His exit was the signal for a minor collapse, four wickets falling for 12 runs, but this, however, was scotched in its infancy by Platt, who, with some bold, bovine blows, compiled a total of 38 not out; Carton-Kelly assisted, sometimes in a similar manner.

The old batsmen of Whitgift fell to the joint subtlety and guile of Trist (four for 26), Carton-Kelly (three for 21), and Webb (three for 44), Wright and Turner alone being able to cope with the situation for any length of time, and so their innings closed 48 runs behind the Guy's total.

Team.—E. W. Graham, Williams, Carton-Kelly, Trist, Munro, Webb, Harvard Davis, O'Driscoll, Allanby, Dyer, Platt.

Scores.—Guy's, 168 (Harvard Davis, 40); Old Whitgiftians, 120 (Trist, four for 26, Carton-Kelly three for 21).

GUY'S *v.* BROMLEY TOWN.

(*Played at H.O.P. on Saturday, May* 25*th* 1946.)

Drawn.

Batting on a dead pitch Guy's lost two wickets for 22 runs before Platt joined Munro (25) to mete out stern punishment to the Bromley bowlers. With the score at 80, rain stopped play and tea was taken to minimise the delay. On resuming, Platt was soon out for 39, leaving Graham to make the Guy's total a working majority, before he was out for 44, another excellent innings to his credit.

The less said of the Guy's opening bowlers the better, but Bromley had rapidly scored 74 for three before Nicholson was called on to bowl. With his slow left-arm deliveries bowled to a well-placed field he soon took wickets and, due to his bowling alone, the game ended with a draw very favourable to Guy's. His figures, five for 25, perhaps make him a contender for the place now occupied by an off-break film-fan.

Following a magnificent *ventre-à-terre* catch by Munro in the deep to make Bromley 139 for seven, the wicket-keeper provided the comic relief to a tense situation with an opportunity to run a man out by ten yards. The ball returning to him a few feet wide of the stumps, Allanby, confounding Newton's earlier work on gravity, contrived to attain the sitting position and, moving in ever-decreasing semicircles in a state of jellied incompetence, failed to dislodge a not far distant bail. Later, he accomplished a stump entirely without the aid of the gloved hand, a well-placed pad sufficing. Bromley were then able to play out time with one wicket in hand and 21 runs behind.

Team.—E. W. Graham, Williams, Carton-Kelly, Trist, Munro, Harvard Davis, Dyer, Allanby, Platt, R. G. Nicholson, C. H. Talbot.

Scores.—Guy's, 169 for nine, declared (Graham, 44); Bromley Town, 148 for nine (Nicholson, five for 25).

INTER-HOSPITAL CRICKET CUP.

First Round.

GUY'S *v.* KING'S COLLEGE HOSPITAL.

(*Played at H.O.P. on Wednesday, May* 22*nd.*)

Won by 232 runs.

Guy's, after winning the toss, elected to bat on a wicket delightful to a batsman's heart and in weather unusually fine. The opening pair settled down to score at a rate encouraging in all day cricket, amassing some 60 runs in the first hour. At this stage, however, while at one end Harvard Davis reached his 50, Munro was run out at the other. So Williams joined Harvard Davis. Together they brought the score to the 100, and it was with 132 runs on the board that the latter, while attempting to turn a ball to leg, was out l.b.w., having scored his 85 runs with confidence and grace. Lunch soon followed, and a short time afterwards another Guy's wicket fell enabling Graham to come to the wicket. At 173 Williams, while optimistically trying to hook a ball that deserved of no such fate, was out "leg before" for a score of 58. Graham then proceeded to attack the mediocre bowling with some ferocity and, excelling with the drive and the pull, quickly reached his half century; but, unsatisfied, he continued to score in a great hurry, taking 20 in one over and reached a hundred in 70 minutes. Soon afterwards Guy's declared, leaving Graham undefeated for 109.

After tea, King's commenced their innings with 3¼ hours of play left. The opening pair showed undue respect for the opening bowlers, who were supported by keen fielding, and it was at the first change that three wickets were taken with the score at 32. This was the signal for a collapse, Foxwell and Hobbs alone offering further resistance, and the last wicket fell with 77 runs on the board and fifty-five minutes to spare.

Team.—E. W. Graham, Williams, Munro, Trist, Webb, Harvard Davis, Allanby, O'Driscoll, Dyer, Russell, Billingham.

Scores.—Guy's, 309 for five, declared (Graham 109 not out, Harvard Davis 85, Williams 58); King's College Hospital, 77 (O'Driscoll, four for 11).

Tennis

P. T. Dwyer has been elected Vice-President of the London University Tennis Club. The announcement which appeared in the last *Gazette* was incorrect.

Hospital Information, etc.

Notices

GUY'S HOSPITAL DENTAL DEPARTMENT.

Applications are invited from gentlemen who have held the post of House Surgeon in the Orthodontic Department of a Teaching Hospital or other Institution specialising in Children's Dentistry for the posts of Orthodontic Assistant. Duties consist of the treatment of orthodontic patients under the supervision of the Dental Surgeon, Assistant Dental Surgeon and Registrars in the Children's Department. Attendance is on three sessions per week commencing on October 1st, 1946, and the appointment is for twelve months in the first instance. Honorarium is at the rate of £100 per annum.

Application forms, duly completed, should be sent before July 1st, 1946, to the Dean, Medical and Dental Schools, Guy's Hospital, S.E.1.

Pass List

UNIVERSITY OF LONDON.

SPECIAL SECOND EXAMINATION.

(For Internal Students.)

March, 1946.

B. L. Bisley	P. G. W. A. Lommerse
D. L. Blundstone	A. A. Mason
T. B. Brewin	D. G. May
J. G. Brice	J. D. Morris
R. McL. Brown	I. S. Moss
B. G. B. Christie	R. G. Nicholson
A. K. Doust	A. H. Phillips
P. R. Dove	P. B. Poole
F. G. Ellis	A. J. Salmon
I. E. Evans	I. A. W. Scott
J. H. Evans	E. J. Stafford
R. W. Glenn	B. Taylor
P. W. Head	A. A. Turner
H. A. Hurwood	C. S. Ward
L. Jacobs	B. L. Whitaker
I. G. Johnston	J. L. Williams
L. C. Kreeger	

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION

April, 1946.

Pass.

A. G. Bearn	R. V. H. Goulder
K. W. Bolt	R. C. Hill
D. F. V. Brunsdon	J. G. P. Hutchison
J. F. Cleobury	F. L. Jackson
P. Coling	C. L. Joiner
D. J. Dennison	P. A. W. Lea
J. R. Dickson	N. G. Nicholson
A. E. Doyle	R. Owen
W. E. D. Evans	R. A. Parker
T. R. L. Finnegan	T. N. Reynolds
J. S. E. Gilbart	M. D. Warren

Supplementary Pass List.

PART I.

J. J. Ashken	O. G. Lane
R. L. H. Barnard	E. L. W. Leiser
A. A. Collis	H. W. G. Loudon
D. O. Davies	J. D. Oriel
J. F. de la Fresnaye	P. Sattin
H. Goldschmidt	M. E. N. Smith
P. R. Harben	J. A. Stewart
J. M. Holmes	J. A. Turner
R. W. Hughes	G. F. Vaughan
J. V. Kilby	D. G. A. Westbury
M. Kugler	I. Yentis

PART II.

I. A. H. Munro

PART III.

J. Candy	R. W. Hughes
D. G. L. Davies	R. J. Stanley
J. J. Fingard	R. G. Watson
H. Herbert	J. T. Woodall

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS.

Diploma in Obstetrics.

G. M. Evans

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

M.R.C.P.

April, 1946.

A. Batty Shaw, B.M. (Oxon.)
W. D. Brinton, B.M. (Oxon.)
P. R. C. Evans, M.B. (Lond.)
S. H. Llewellyn Smith, B.M. (Oxon.).
D. P. Nicholson, M.B. (Lond.)

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

May, 1946.

Medicine.

W. F. Belsham J. O. Kelsey

The Services

Mentioned in Dispatches.

Captain D. H. Crook, R.A.M.C., in recognition of gallant and distinguished services in Burma.

Change of Address

Paul Davies, M.B., 191, Sheen Court, Upper Richmond Road, Richmond. (Tel.; Prospect 2995.)

E. Leslie Graff, M.B., B.Ch., 9, Weymouth Street, W.1. (Tel.: Langham 3925.)

C. V. Kark, L.D.S. R.C.S., 29, Hatfield House, Corner Eloff and President Streets, Johannesburg, S.A.

W. A. Mill, M.S., 22, Harley Street, W.1. (Tel.: Langham 1923.)

W. L. Renouf, L.D.S. R.C.S., Whitecroft, Queen's Road, St. Helier, Jersey, C.I.

C. S. Darke, Lt.-Col., R.A.M.C., No. 1 British Military Hospital, P.O. Box 4026, Nairobi, Kenya.

E. I. Davis, M.R.C.S., L.R.C.P., Lanes End, Cranleigh, Surrey.

P. C. Grummitt, Surg.-Lt. (D.), R.N.V.R., H.M.S. *Gervsalemme*, c/o G.P.O., London.

H. Fletcher Lunn, M.B., B.S., 18, Merrick Square, S.E.1.

W. A. Steiner, B.D.S., 3, Fairfield, Salterton Road, Exmouth, Devon.

P. E. Tollit (Miss), The Matron, Chalfont Colony, Chalfont St. Peter, Bucks.

J. G. Davimes, L.D.S., R.C.S., 42, Hfgh Street, Berea, Johannesburg.

P. G. Epps, M.B., B.S., Brambletye, Lyminge, near Folkestone, Kent.

T. B. Layton, D.S.O., M.S., The Shaws, Newchapel Road, Lingfield, Surrey (Tel.: 338.)

J. R. Trounce (323913), Capt., R.A.M.C., 23 Military Hospital, Bergkerchi.

Births

FUNG.—On April 26th, 1946, to Joan Mary Fung (née Ballard), wife of Oswald C. Fung, Lieut., R.A.M.C.—a son (John Carlton).

LOMAX.—On April 29th, 1946, at "Yallands" Maternity Home, near Taunton, Somerset, to Joan (née Stapley), wife of H. R. Lomax—a son (Robert Anthony).

Marriages

STEINER—BEATTIE.—On April 27th, 1946 at St. Mary's, Aylesbury, Walter Steiner, younger son of Mr. A. Steiner, and the late Mrs. Steiner, of 60, The Drive, Ilford, to Doreen Beattie, elder daughter of the late Sqd.-Ldr. H. Beattie and Mrs. Beattie, of Aylesbury.

CADMAN — TOMKINS - RUSSELL. — On May 4th, 1946, at the Chapel Royal, Brighton, Albert Edward Cadman, Surg.-Lt. (D.), R.N.V.R., son of Mr. and Mrs. E. A Cadman, of Herne Bay, Kent, to Margaret H. Tomkins-Russell (Second Officer, W.R.N.S.), elder daughter of Mrs. W. H. Tomkins-Russell and the late Rev. W. H. Tomkins-Russell, of Thrapston.

TAYLOR—GOLDSCHMIDT.—On May 11th, 1946, at St. Mary's, Putney, Brian H. Taylor, Capt., A.D. Corps, to Susan A. Goldschmidt, S.R.N.

EDS. {R.H.N.L. J.E.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

IT is always a pleasure to record honours bestowed upon Guy's men, and we congratulate Air Vice-Marshal Conybeare, Major-General Covell, and Mr. Kelsey Fry on the high distinctions conferred upon them in the Birthday Honours List. Many honours fell to Guy's men during the war, and it proved impossible to enumerate them all in " Passim " ; but with these latest awards we recall all those of the last six years. Through the honours bestowed upon them, these men have brought honour to their hospital.

WE are glad to announce the appointment of Lord Cunliffe as Treasurer of the Hospital in succession to the late Mr. John E. Humphrey. Lord Cunliffe has been a Governor of the Hospital for many years, and we look forward to his presence here for many more years as Treasurer.

DURING the war no new appointments were made to the Visiting Staff, and a number of places fell vacant as the more senior members retired, and as death took its toll without respect for age. Now, with the return of peace-time conditions, the vacancies which have appeared begin to be filled, and at a meeting of the Court of Governors on June 3rd a number of new appointments were made. Guy's has always been fortunate in the members of its Visiting Staff ; not only for their work and teaching, but also for the spirit in which they serve the Hospital. Many of those newly honoured are well-known to the present generation of Guy's men ; we welcome them in their new rôles, certain that they will be equal to the stern tradition in which they follow. To those new to us we extend as warm a welcome. We offer our heartiest congratulations to all the following on their appointments :—

Mr. S. H. Wass, to be Assistant Surgeon.
Mr. J. S. Batchelor, to be Orthopædic Surgeon.
Dr. W. N. Mann, to be Assistant Physician.
Dr. C. Hardwick, to be Assistant Physician.
Mr. P. V. Reading, to be Surgeon to the Ear, Nose and Throat Department.
Dr. P. M. F. Bishop, to be Endocrinologist to the Hospital.

ON Wednesday, June 12th, we were honoured by a visit from Dr. Sterling Bunnell, Consultant in Hand Injuries to U.S. Secretary of War. In a most instructive lecture, Dr. Bunnell outlined the principles of reconstructive surgery of the hand, stressing the importance of co-operation between the many specialists whose various fields meet in the human hand, and illustrating both the operative technique and the results which had been obtained by a number of colour films.

EARLY this year, four recently qualified Guy's men, more enterprising than their fellows, decided on an unusual way of spending the few months at their disposal between qualification and call-up. Setting off as soon as their exams were over, they spent three months in Sweden working and learning in several of the biggest Swedish hospitals. We hope to publish an account of their adventures shortly.

Meanwhile, as a direct result of their visit, we welcome here two Swedish students who are spending three weeks at Guy's, living in the College as guests of the Medical School. We wish them a pleasant and profitable sojourn in our midst.

A Case of Acute Intestinal Obstruction Caused by a Dried Peach

Presented by E. F. SOOTHILL
(with the kind permission of Mr. Slesinger).

MRS. P., aged sixty-three years, was sent to Guy's by her doctor at 4.30 p.m. on February 17th, 1946, as an acute abdomen.

History.—During the previous night the patient was awakened by severe abdominal pain, which was apparently generalised over the lower abdomen, and of "colicky" type, being continuous with exacerbations sufficiently severe to double her up. She eventually had some relief with aspirin and had about one hour's sleep. The pain returned in the morning and continued until admission. She vomited several times over the whole period, the vomit being clear fluid. She had one good bowel action at 9 a.m. on the day of admission.

On questioning the patient about her past history, she said that her appetite had been poor, and that she had lost some weight. Her bowel action in the last six months had become more frequent and was fluid in nature, but there had been no blood.

Condition on Admission.—Temperature, 97.6 ; pulse, 96 ; respiration, 20.

On Examination.—General : The patient appeared to be in considerable pain. She was of a good colour, but appeared to have lost some weight and looked dehydrated.

Mouth : The tongue was clean and the patient was edentulous.

Abdomen : The abdomen was distended to a mild degree, particularly around the umbilicus. The outline of coils of intestine could be seen, with some visible peristalsis.

On palpation the abdominal wall was lax and there was no guarding. There was no sign of any external hernia. In the right iliac fossa a freely movable and painless lump about 2 in. by ½ in. in size could be felt. Little attention was paid to this.

Diagnosis.—It was thought that this might be a subacute obstruction due to a carcinoma of the cæcum or ascending colon. This was supported by the history of altered bowel habit, loss of weight and appetite, and by the palpable lump which, under this circumstance, could have been a secondary deposit in the omentum.

It was accordingly decided to observe her and she was given an enema, which produced a fair result. She was also given fluids by mouth, and an intravenous saline drip was set up to reduce the dehydration.

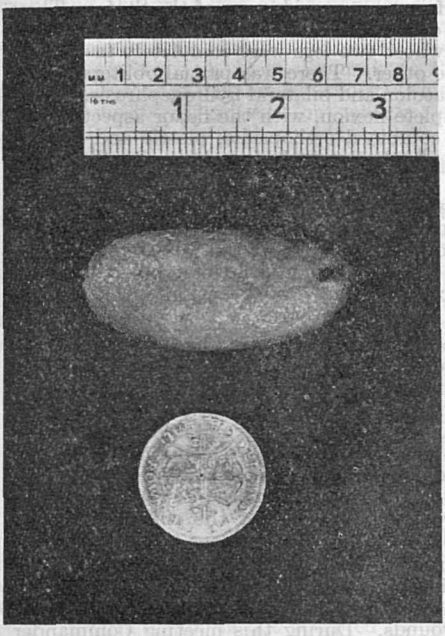
Progress.—On the next morning the patient was little changed. The dehydration was less, but the vomiting was persistent and was bile-stained a deep green colour. One further enema produced a small result. She was still having colicky pain, and the presence of visible peristalsis was now certain. It was decided to operate.

Operation.—A right paramedian incision was used. On opening the peritoneum a little clear blood-stained fluid was present. Coils of gas-distended small intestine with œdematous and injected walls welled up through the incision. On following the small bowel distally a mass was found within the lumen, about four feet from the cæcum. Beyond this mass the small intestine was collapsed. The mass was soft, about 3in. by 1in., fusiform in shape, and could be moved proximally along the lumen of the distended bowel, but not distally.

The bowel was clamped above and below the foreign body and opened by a small transverse incision. The foreign body was removed and the bowel was sutured, the suture line being invaginated. The abdomen was closed with sutures.

Post-operative Progress.—The patient progressed satisfactorily with no abdominal complication. She developed a pneumonia, which was treated with sulphamezathine, and she recovered completely.

Foreign Body.—On examination this was found to be half a dried peach, rolled up at the edges into a sausage-shaped body, 3in. in length by ¾in. in width. It was soft, but firm and rubbery in texture. (See photograph.)



On later questioning, the patient admitted eating on the previous evening a dried peach without previously soaking it in water, and that her dentures were inadequate for chewing hard food.

SUMMARY.

Several cases of intestinal obstruction due to dried food have now been reported (1), but the condition is a rarity. Of foreign bodies that impact in the small intestine, large gall stones constitute 70 per cent. of cases. (2) In these cases the foreign body is often palpable in the right iliac fossa.

In this case, however, the impaction of a foreign body was not diagnosed preoperatively. A straight X-ray of the abdomen might have proved helpful by revealing fluid levels in the small intestines.

REFERENCES.

(1) Lyall, A. 1945. *Brit. Med. J.*, 734.

(2) Handfield-Jones, R. M., and Porritt, A. E. 1943. "The Essentials of Modern Surgery." 2nd ed., p. 632.

A Tour of the United States Plastic Surgery Centres

By PATRICK CLARKSON, M.B.E., F.R.C.S.

PART II.

THE middle six weeks of this tour was spent, first, between San Francisco and New York, then from New York down the Atlantic Coast to Valley Forge, Philadelphia, and Baltimore. Another visit to Washington was followed by visits to White Sulphur Springs, West Virginia, and a return to the mid-West, at Indianapolis, before coming back again to Washington.

My chief visits on this trans-continental passage to New York were to Springfield, Missouri, St. Louis, and Chicago. At St. Louis I called on Dr. Vilray P. Blair. Dr. Blair is, of course, one of the fathers of plastic and oral surgery, and has made very special contributions to our knowledge of cancer of the mouth and face, with special reference to the ablation of the cervical glands, and to the repair problems following excisions of the face for malignancy. A most instructive and stimulating morning was spent at his office, watching him plan the repair of a variety of facial defects. Facial repairs following excisions for malignancy are seldom started within a year of the ablation of the growth. Too many surgeons have had the distressing experience of seeing an early repair destroyed by a recurrence—a recurrence whose early recognition, furthermore, has been made more difficult by the repair.

That afternoon, Dr. Blair's partner, Dr. Byars, took me round the Burns Wards at the Barnes Hospital, and at the Barnes I met Dr. Evarts Graham, with whom so many chest surgeons from Britain and elsewhere have trained.

Cases of severe burns come to St. Louis from a very wide area of the States. They arrive at all stages and many bizarre late deformities are referred to them for their treatment. I remember particularly a girl whose two legs were completely fused, one femur being in contact with the bone of the other. There was partial obliteration of the perineum by scar tissue ; she had a megacolon and bilateral hydronephrosis. There was another whose hand was fused, in complete flexion, with the flexor aspect of the forearm. Such cases present very special combined orthopædic, plastic and general problems, and Dr. Byars' most kindly and clearly detailed his policy with these and similar cases.

The chief reason for my visit to Chicago was to see Dr. Summer L. Koch. Dr. Koch was, of course, the late Dr. Kanavels' partner in his masterly book on the surgery of hand infections. I had the good fortune to visit his clinic at the Passavant and see there in one morning over thirty different diseases and injuries of the hand, which were attending as out-patients. These included some very beautiful full thickness grafts to the fingers for the repair of X-ray and radium burns.

It was during stops between San Francisco and New York that I began to appreciate that the normal rhythmn of dinner is in reverse in the U.S. It is this way. Whereas in England, though dinner-party conversation may be sticky with the soup, the tempo improves under the warming influence of wine* throughout the meal. In the United States the effect of the concentrated pre-dinner highballs is for a table of complete strangers to sit down for dinner, talking at the liveliest pace. During the soup it is difficult to get a word into this brisk flow of conversation. Water only is taken with the meal. By the time the sweet is served the atmosphere is more like the soup course in England, from somnolence, while the reviving influence of the coffee is eagerly awaited by all.

At New York the Plastic and Re-constructive surgeons of America were holding their annual meeting under this year's President, Dr. Gustave Aufricht. A variety of plastic problems were discussed during the week, but the bias was very much on injury and the repair of body and hand wounds. During this meeting Commander George Webster showed a very complete colour film on re-constructive hand surgery, which had been done for naval casualties at Bethesda Naval Hospital. The film illustrated the extent to which the U.S. Navy have supplied their medical units. Commander Webster gave the cost of this single medical film as $25,000. It was, of course, an excellent film. Next to trauma the repair of the face, following excisions for malignancy, was the major subject discussed. These repairs are complicated by the age of the patient and it is for patients who have had facial excisions for malignancy that prostheses are most likely to be of value ; of these facial prostheses the best at present are of vulcanised latex and soft acrylics.

The meeting did not pass without some reference to the more cosmetic aspects of plastic surgery. One morning was enlivened by a very brisk debate on mamaplasties. In this argument Dr. Jerome Webster championed the method of free grafting the nipple together with the erectile musculature—a piece of surgical technique of the greatest virtuosity, which, in his hands, is successful. (I later saw him do this operation and examined some of these cases.) On the other hand, Dr. Bames, of Los Angeles, who has probably done more breast reductions than anyone else in the world, transposes the nipple on a pedicle of breast tissue ; if it is more than 2½ in. dependent, he does a two-stage operation. He has a very extensive set of kodacromes, illustrating his operations for localised adiposity, and his very excellent results in the relief of massive breast hypertrophies.

This New York meeting was my first American Medical Congress. It was held at the Waldorf, and followed the classical and most agreeable pattern of U.S. medical congresses. The morning was spent at hospitals—the Naval Hospital (Long Island), the Post Graduate, the Memorial and others. Lunch was at the Waldorf, and the afternoon was passed in the Conference Room at the hotel listening to papers. Cocktails before dinner, and a formal dinner with speeches, by no means ended the discussions for the day, which continued at a lively pace in groups in hotel bedrooms.

A feature of the American life was impressed upon me during this visit. It is that the margin between the most expensive and cheapest restaurants is narrow, both in cost and in quality of food served. It was my practice when travelling across the States to eat at the cheapest restaurants to be found near railway stations. Excellent meals of the steak—ice-cream—coffee formula at about a dollar were to be had everywhere. In New York, at the very best restaurants, food of a very similar sort was

* When available.

served, and the price was about double—2 to 2.50 dollars. The margin in pre-war Europe between the best and the cheapest restaurants was certainly much more than 100 per cent. in price, and the margin in quality between a Michelin three-star meal at La Roues and the cheapest restaurant in Paris was very nearly unmeasurable. An especially pleasant gastronomic memory of this tour was the Colony, where Dr. Aufricht introduced me to cold grilled trout with horseradish sauce—a combination new to me and, happily, available in this country.

My tour of plastic centres was interrupted at this stage to visit paraplegic centres at Staten Island and Atlantic City. There are about 1,500 paraplegic patients in U.S. Army hospitals. I visited in all five centres of 60 to 120 beds. These centres are at hospitals at which there are also orthopædic and neurological units. There is no doubt that in the treatment of this difficult and complex condition the U.S. is very advanced, and that the high standard of their results depends upon the successful way in which the work of a number of specialists has been integrated, rather than on any special treatment.

Paraplegias present five major problems in treatment :—

(1) The Urological problem ;
(2) The Neurological problem ;
(3) The Orthopædic problem ;
(4) The Dietetic problem ;
(5) The Plastic problem of the Decubitus ulcer.

Briefly, the urological problem concerns the elimination of infection and of calculi, and the control by the patient of the capacity of the bladder. Tidal drainage, as taught by Dr. Munro, of Boston, is an integral part of the treatment, supported by early heavy streptomycin, and—for a very small minority—resection of the bladder neck. A catheter life is not accepted as necessary, or as other than a confession of surgical failure for the paraplegic. At one centre visited, 60 out of 63 cases were dry, and at another 87 out of 91. The mortality during the first year in the States for these casualties has been 1–2 per cent.

The neurological problem concerns the relief of pain and of muscular spasms. For about 10 per cent. pain may be sufficiently severe to warrant chordotomy or rhizotomy.

The orthopædic problem concerns the training in ambulation. The patient must not be dependent upon a wheel-chair life, and he should be able to drive a car. He walks with the aid of crutches and braces. C 8 with power of hand grip must therefore be intact for this result.

The dietetic problem is of especial interest, in that these patients, as a group, were more wasted than any other type of casualty on return to the U.S. Protein loss is the chief factor, and protein over-feeding is the basis of therapy. A positive nitrogen balance is essential for the healing of the injured nerves, the healing of decubitus ulcer, and for their morale.

The answer to the bed-sore in the paraplegic patient has been provided by Major Croce, of Halloran General Hospital, who has shown that these ulcers can be closed by local tissue after radical excision. The essential conditions before this repair is done are that the edge of the ulcer is sealed-off with an epithelial response, the patient has a positive nitrogen balance, and the ulcer is free of hæmolytic streptococci. He showed a large series of ulcers up to 20×12 cm. in area, which had been successfully closed and healed by rotation flaps. (Fig. 1).

From Atlantic City I went to Valley Forge, where Colonel James Barrett Brown has the largest plastic centre in the U.S. He is supported there by Lt.-Col. Bricker, the late plastic adviser to E.T.O., and Lt.-Col. Bradford Cannon, of the Massachusetts General Hospital. Of the 1,800 beds about two-thirds are body plastics, in which the Plastic Department co-operate with Neurological and Orthopædic departments, by providing a suitable closure of the wound by local, or belly-to-arm flap, or by tube pedicle, before the patient has his nerve or bone graft.

Closures from local tissue have been highly developed, especially strap flaps with grafts to the secondary defect. Less cross-leg flaps for limb defects below the knee were seen than is usual in British plastic centres. Colonel Brown uses ribs for his mandibular repairs. I examined about twenty of these bone grafts which had good firm union at about eight to ten weeks and a very excellent contour restoration.

It was of special interest to see that Colonel Brown, like Dr. Jerome Webster, of New York, uses the Tagliacotius arm method of repair for his noses. The opinion in the U.S. is that forehead scarring contra-indicates the use of forehead flaps for making a complete nose. They base this opinion on experience of forehead rhinoplasties seen abroad. The arm rhinoplasties are more difficult to do, but, in good hands, are eventually excellent in form. Some remain pale, but one seen at Valley Forge, which had been done more than a year, had blended in quite perfectly.

EXCISION AND ROTATION FLAP CLOSURE OF SACRAL BED SORE

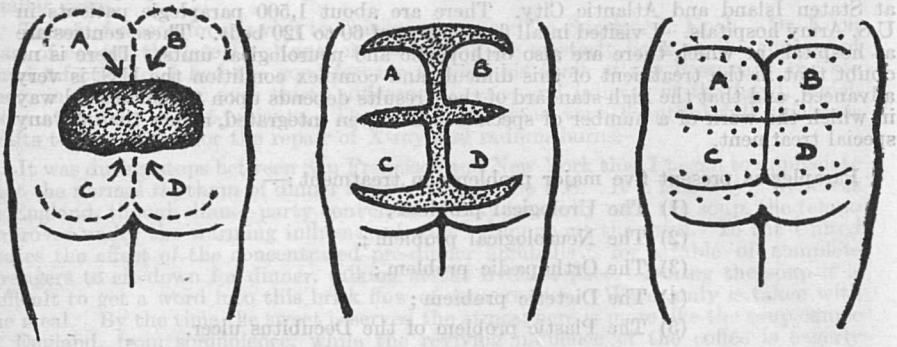


FIG. I.—These figures illustrate the method used with great success by Major Croce in the treatment of the bed sores (of 18×12 cm.) of paraplegics. Some edge loss particularly at the centre point where the flaps meet may be expected; healing should be complete 3–5 weeks after operation (in these diagrams the pedicles of the flaps are a little too narrow)

A special and most valuable development of Colonel Brown's has been the use of composite ear grafts for ala defects. (See Fig. II). In this operation a wedge of the full thickness of the margin of the ear is sewn as a free graft into the freshened ala defect. Its success possibly depends upon immediate canalisation of the abundant capillaries of the ear skin.

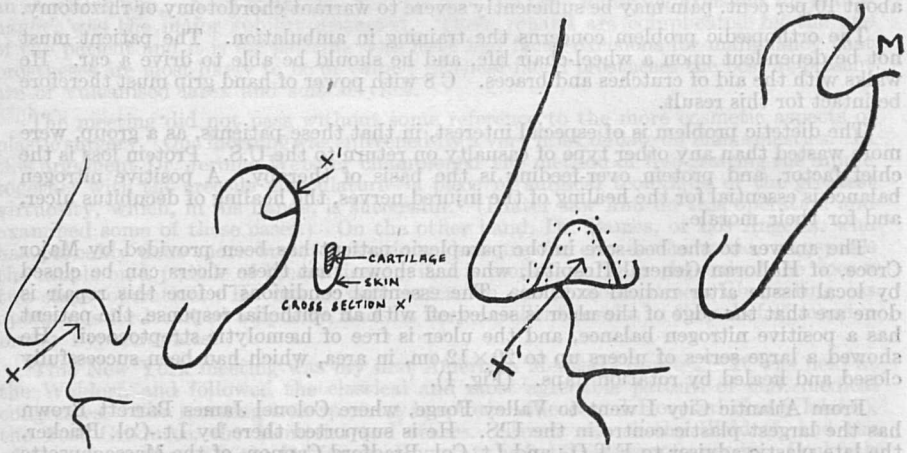


FIG. II.—Colonel J. Barrett Brown's repair of defects of the nasal alae (X) by composite grafts of the ear margin containing auricular cartilage (X^1). The secondary ear defect is closed by a mastoid skin-flap.

Altogether I had a most stimulating and instructive ten days at Valley Forge, and I was shown very great kindness. This visit was well timed, because shortly afterwards, Colonel Brown left to take up the appointment of consulting plastic surgeon to the Veterans' Association in Washington.

Valley Forge is, of course, a place of the greatest historical importance to America. It was there that George Washington's fortunes reached their lowest ebb. While his

opponents, Lord Howe and his men, wintered thirty miles away in sensible Philadelphia billets, George Washington had to stick it out on the icy slopes of Valley Forge. His forces melted away during the long winter nights, but what remained was good stuff. The spring found them in fine fighting form, and they got off to an early though small victory; from that moment they never looked back. Furthermore, they had had some intensive bayonet practice during the winter under German tuition. Hitherto, the rebels had been a little squeamish about "Rosalie," both with and against her. Early that spring, by the use of the bayonet alone, they mopped up a complete British outpost. This success left them devoted to the bayonet and had cheered them greatly.

Washington's regimental commanders included a Colonel Gamaliel Bradford. It was a particular pleasure to meet again at Valley Forge Hospital, Dr. Charles Bradford, whom many will remember with the American Hospital in Britain at Basingstoke in 1940–1. He had since spent the War in the Pacific as M.O. to a Paratroop Regiment, which had done the jumps in General McArthur's advance from Australia to the Philippines. These conversations with officers from the Pacific War were one of the most interesting experiences of my tour, as I had hitherto been very ill informed of events in that Theatre. I had not appreciated how enormous was the fire and power which the U.S. Army and Navy were finally able to fling against the Japs. Corregidor was re-taken by a paratroop unit which lost 189 men in the accomplishment of this brilliant military feat; they counted over 6,000 bodies of Jap defenders.

Valley Forge is a good place for history. I learnt there the distinction between the early Brownist colonies in Massachusetts, with their practice of complete toleration, and the nearby Puritan Colonies, who did not tolerate much, certainly not the toleration of their neighbours the Brownists. Nor previously had I seen U.S. history in terms of waves of liberalism, and anti-trust movements—although a see-saw between conservative and radical elements can, of course, be traced in most national histories. In U.S. history it was traced for me in the Jeffersonian reaction against President Adams with his government of "the rich, the well-born and the able." After Jefferson the gradual growth in the power of trusts led to the reaction of Andrew Jackson, who again did not completely destroy them. Teddy Roosevelt in a sense represented in the early twentieth century the same anti-trust and liberal forces of Jefferson and Jackson. Mr. Franklin Roosevelt supported the same political philosophy, qualified by a different attitude to the judiciary.

From Valley Forge I returned to Washington *via* Philadelphia and Baltimore. In the Philadelphia Naval Hospital, where Captain Waltman Walter, of the Mayo Clinic, is Chief of Surgical Service, Commander Dupertuis showed me a large and interesting group of two special plastic problems; the repair of eye-lid and socket injuries, and the repair of guillotine amputation stumps. For the eyelids Wheeler operations were used when applicable. For the re-surfacing of raw guillotine stumps, Commander Dupertuis used cross-leg flaps and tube pedicles in selected cases.

The U.S. Navy, like the U.S. Army, made routine use of the guillotine for primary amputations. There is common belief there that the guillotine was one of the great life-savers in the War. In this connection, the B.L.A. figures for gas-gangrene are interesting. British surgeons always fashioned primary flaps when possible. In over 100,000 wounded in B.L.A. there were only 300-odd cases of clostridial myositis; 20 per cent. of these died. An incidence of less than 3 per cent. and a mortality of less than .06 per cent. for gas gangrene is about as good as possible in European warfare. In the U.S. 3rd Army, in which guillotines were the routine amputation, there were approximately four hundred cases of gas gangrene in just on 100,000* wounded men, *i.e.*, about same incidence as B.L.A. who fashioned primary flaps.

At Baltimore it was a special pleasure to be able to meet Dr. Staige Davis, one of the first full-time plastic surgeons in the world, and first author of a book on plastic surgery in English, who is too a Civil Plastic Consultant to the Army. I had the good fortune to see him operate and hear his opinion on a variety of subjects. With Dr. Kitlowski, he has taken a special interest in the construction of the extra-thoracic oesophagus. Now that the stomach is mobilised into the thorax more often, this repair is less often necessary. When it is, the excision of a medial portion of the clavicle to produce a soft bed for the new gullet and reduce the incidence of trouble at the point of junction here between pharynx and re-constructed œsophagus is sometimes recommended.

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* The mortality in 3rd Army area for this 100,000 wounded was the phenomenally low figure of 2.7 per cent.

Following Baltimore I spent a week at Colonel Daniel Elkins' Vascular Centre at White Sulphur Springs. This centre is the largest vascular centre in the U.S. Since the start of the War they have treated well over four hundred arterio-venous and traumatic aneurysms by operation. The standard operation for A–V aneurysms is quadruple ligation and excision; for the false aneurysms, the classical Matas endaneurysmorraphy is done. Colonel Elkins stresses the importance of anatomy in vascular surgery and the value in this work of Professor A. K. Henry's monograph on surgical approaches. His operation successes include an innominate A–V aneurysm, more than half-a-dozen occipitals, and six carotico-cavernous aneurysms for pulsating exophthalmos.

Before flying to Canada from Washington I visited the plastic wards of Lt.-Col. Truman Blocker, near Indianapolis, Indiana. This is a very active centre. Colonel Blocker has taken especial interest in methods of stainless-steel suture. His suture lines for body plastics are beautifully free from reaction and marking of any sort. Stainless-steel, either subcutaneously or as interrupted sutures, can be a most satisfactory material to use, especially for closure of body wounds. Of special interest was the use Colonel Bocker was making of blocks of iliac medulla for his mandibular bone grafts. He was getting rapid rates of consolidation for big gaps—six to eight weeks for 10 cm. gaps. Another clinical interest which has been developed by Colonel Blocker since 1936 has been in the treatment of chronic osteo-myelitis of long bones. This treatment comprises the radical removal of all infected bone, sinus tract and scar tissue, and the immediate application of a thin free skin graft to the bony cavity. Such cases which may have been sequestrating for months or years are commonly dry and healed after four to six weeks. This method is particularly applicable to the osteomyelitis of missile wounds, and Colonel Kelly, of the Ashford General, has, too, used it extensively for the last three years. I examined over thirty such cases at different hospitals during my tour. There is no doubt that it is a valuable method of calling a halt to a tiresome sequestrating sinus-ridden wound; but, for the majority of cases, the skin graft is only one stage of the treatment and the later soft tissue flap and the bone replacement need very careful planning.

Orpington Letter

(We apologise for the unavoidable delay in publishing this letter.—Ed.)

THE last month at Orpington has seen the departure of Miss M. Marriott, who has been with us for six years, first in the capacity of Assistant Matron in charge of the Guy's Unit, and later as Matron of the Hospital; and it would seem fitting here to pay some small tribute to her work which, especially at first, has been carried out amidst great difficulties.

The many problems which come the way of a matron in a peace-time hospital of fixed constitution must be trivial indeed compared with those of an institution for chronic sick rapidly converted into an emergency hospital, and governed by three distinct bodies—Ministry of Health, County of Kent, and Guy's Hospital, with three separate nursing units (Guy's, County and C.N.R.).

Despite all these difficulties Miss Marriott has succeeded in producing a remarkable degree of unity and the smooth running of the hospital from a nursing point of view is a creditable monument to her ceaseless endeavours.

A supper-dance was given in her honour here recently—a feast indeed, which saw many who had worked here in the past and hence departed, back again to wish her well in her new and honourable appointment as Matron of the Middlesex Hospital.

In the same week we lost Arthur Rushforth to the Royal Air Force. The latter has been here for over three years as Orthopædic Registrar and has done an immense amount of work during that time. No one who heard the testimony of his chiefs at his "going off" dinner could doubt the high quality of his surgery, but, apart from this, we will miss him as a colleague and as a gentleman.

B. D. J.

"French Without Tears"

HOW stimulating to the appreciative playgoer is the conversation "typically Coward" and the epigram "typically Wilde." If we do not already murmur "typically Rattigan," I think we shall very soon, for Mr. Rattigan has a most engaging and distinctive style. In no play of his is it more delightfully apparent than in "French Without Tears"—presented by the Theatre Club last week. All the intrinsic ingredients of an effective comedy are there, strewn about in joyous profusion. The dialogue scintillates, the characters, with two regrettable exceptions, are thoroughly well conceived, plausible and carefully balanced, the plot (though slow to develop in the First Act) is good and the action beguiling. Well performed this is a comedy of the first order; badly performed it is a farce, and a farce which is intended to be a comedy is a tragedy. Mr. Rattigan has given his actors the tools. It is up to them to finish the job. Comedy or "tragedy," which shall it be? There is no compromise, not even for typical Englishmen in the South of France.

I suppose the Theatre Club might easily have made their large audiences croak with discomfort, for it is usually the amateurs who murder the comedies. What they did, instead, was to raise the loudest outbursts of laughter heard at Guy's in recent years, and leave behind them at the end (and this is a far more reliable indication of their worth) a fine impression of competent acting and producing which can rarely, if ever, have been surpassed in the Hospital before.

This praise, well deserved though it is, does not imply a flawless performance. Judged by professional standards there were several faults, but what is taboo and scorned at the Haymarket is warmly applauded in the Physiology Theatre. Let us leave it that. After all, we are here concerned with the Physiology Theatre; no doubt the faults could and would have been remedied at the Haymarket.

Miss ROWENA SANDERS and Mr. GRAHAM BLEWETT were responsible for two most satisfying performances. Miss SANDERS is an immaculate actress. Her accent throughout was as clear as it was enchanting, and her movements were an object lesson in poise and deportment. Her affair with Kit is the one serious feature of the play, and it is to the credit of Miss SANDERS and Mr. MCGUIRE that it was conducted without a trace of incongruity. Mr. Agate may have found something detrimental to say about Miss SANDERS; I am not Mr. Agate and I can find nothing. The exuberant Mr. BLEWETT was supremely funny. No actor at Guy's could have played Brian so well. I wonder why he *was* so funny; he was almost inaudible at times. This says a great deal for Mr. BLEWETT'S personality.

There is an indefinable quality about Mr. TED MCGUIRE which compels attention. He gave us a finely modulated performance as Kit and his love-scene with Jacqueline was beautifully done. Mr. MCGUIRE can hold the stage at will and yet hand it to others when the occasion demands. Miss PAMELA WILCOCK had all the allure that Diana should have. Probably half the audience felt the same way about her as Kit and the Commander. There was, however, a certain hesitancy of movement which suggested a lack of that complete assurance which Diana should possess in superabundance, but Miss WILCOCK spoke her lines with a delicious naivety and one felt, when the final curtain came down, that Alan had a most exciting time ahead of him.

Let us forget Mr. Rex Harrison and Mr. Ray Milland when assessing Mr. TONY BREWIN'S performance as Alan Howard. This was quite a different Alan, without some of the brittle cynicism we might expect from him. I think it is important that one should like Alan at the outset, just as one should like Algernon in "The Importance of Being Earnest." Mr. BREWIN succeeded here where others might have failed. Mr. BREWIN is a very capable actor-producer, and if this part didn't suit him as well as others he has played—he is more at home in a dramatic part—he nevertheless proved himself a master of stage-craft.

As the Commander, intoxicated and embittered, Mr. JOHN HAYWARD would have delighted Mr. Rattigan and Mr. Roland Culver as much as he delighted his audiences. This was the highlight of his performance—and a very brilliant highlight, too. At other times, when he was incidental rather than essential, he was not always consistent and in appearance he was not always mature. Mr. HAYWARD, however, clearly has a sense of comedy and he made the most of it.

In my opinion, Monsieur Maingot's part is badly written and Kenneth's is hardly written at all. In the circumstances one must congratulate Mr. MICHAEL COPLANS

and Mr. ALAN MCLAUGHLAN on making the best of poor and inadequate material. Somewhere, in some play, there is a part which will give full scope to Mr. COPLANS' capabilities. I hope it is found before he leaves the Hospital. It was a touch of genius to ask Mr. FORSDICK to portray the innocent English peer in his 'teens, and Miss TUCHBAND was ideally cast as Marianne.

Behind the scenes quiet efficiency reigned. No praise is too high for the back-stage specialists who made this play possible. The team-work was magnificent; each man and woman had a particular job to do and did it. The success of the production owes much to Messrs. THOMSON, STEBBING, CHALMERS, NICHOLSON, WAGNER and MANN, and to Misses CHILTON and FEW. Never in the limelight yet responsible for creating it, these people were indispensable and indefatigable. The set, the lighting, the stage-managing, the effects and the décor left little to be desired. Particularly effective was the incidental music which immediately preceded each Act.

The play was produced by Mr. BREWIN and Mr. COPLANS. In their hands failure would have been impossible. What a high standard they achieved.

R.H.N.L.

Correspondence

House Appointments

SIR,—I should like to say how much I enjoyed reading the correspondence in the last edition of the *Gazette*, especially the literary masterpieces of Mr. Stafford-Clark and Mr. K. D. Allanby.

I have been stimulated to submit a comment on the subject of House Appointments at Guy's.

While agreeing most heartily with Mr. Trusted's observations on the appointment of certain of the ex-service doctors to Guy's, I feel that he overrates the present advantages of the Guy's House Appointments.

The best rehabilitation for ex-service doctors, many of whom have been medically inactive during the war, is an intensive course in practical medicine.

It has been my experience, during three years residence at Guy's, that such a course is not available, and now becomes less likely with the increasing number of Housemen appointed.

It is hardly likely that ex-service doctors will profit by another period of inactivity, and they would be well advised to go further afield.

Yours faithfully,

W. J. STEVENS.

Redhill County Hospital,
Edgeware, Middlesex.

Intramuscular Injections

SIR,—May I be permitted to draw attention to the technique of giving intramuscular injections? This is a common daily procedure and will soon assume a greater importance as the administration of penicillin by this route increases.

The standard method nowadays still seems to be an injection into the buttocks. This bad practice cannot be too strongly condemned. Everybody knows its inherent dangers, and yet it is done regularly. The alternative and the method of choice is to give the injection into the bulk of the muscle of the lateral part of the thigh. It is as simple as it is safe. The greater trochanter and the lateral epicondyle of the femur are identified and the injection given anywhere in a line joining these two points. The needle is thrust deep obliquely through the skin and tensor fascia lata, where the characteristic crispness can be felt as it goes through and one is immediately in the muscle where the injection should be given. It is safe because in this region there are no large blood-vessels or nerves, such as the sciatic nerve; besides, with multiple three hourly insertions, there is a wide area available on both thighs where the site can be varied to the advantage of the patient.

I am, Sir,

I. T. THE.

Nuffield House,
Guy's Hospital, S.E.1.

Sport

Cricket

INTER-HOSPITAL CRICKET CUP.

Second Round.

GUY'S *v.* MIDDLESEX HOSPITAL.

(*Played at H.O.P. on Thursday, June 6th.*)

Won by 254 runs.

In good weather, Guy's won the toss and elected to bat; but with only 4 runs on the board Williams was bowled and Platt joined Harvard Davis. These two batted confidently and soon settled down to a fast rate of scoring; but with the score at 76, after 45 minutes' play, Platt was caught. Another wicket fell with the next ball and Graham joined Harvard Davis. The former attacked from the start and together they sent the hundred up in little over the hour. Harvard Davis then reached his half century but was bowled soon after. Trist came in when another wicket had fallen, and lunch was taken with the score at 179 for 5.

Refreshed by the rest, Middlesex fielded with vigour, but their bowlers were unable to keep the Guy's batsmen quiet and soon the 200 was reached. With 25 more on the board, Graham was caught, having knocked up 110 in 1¼ hours. Soon after, Trist followed his captain to the pavilion—for 45; together they had scored over a hundred. He had batted with complete confidence, making good use of the short single. The last four men added another 40 runs to bring the total to 300.

Middlesex, tired after their strenuous time in the field, never looked like getting the runs. O'Driscoll took the 1st wicket with his 2nd ball and he, together with Russell, continued to take wickets at short intervals. They bowled with remarkable accuracy as their analyses show; O'Driscoll taking 4 wickets for 4 runs in ten overs, eight of which were maidens, while Russell took 3 for 26. It was left to Nicholson with his slow left arm deliveries to dispose of the last two Middlesex men with consecutive balls, their total being 46.

Scores.—Guy's Hospital, 300 (Graham 110, Harvard Davis 51); Middlesex, 46 (O'Driscoll 4 for 4).

Team.—E. W. Graham, Williams, Trist, Harvard Davis, Platt, Dyer, O'Driscoll, Russell, Talbot, Nicholson, Gillett.

GUY'S *v.* WOOLWICH GARRISON.

(*Played at Woolwich on Sunday, June 9th.*)

Lost by 35 runs.

With the previous day's match rained off, Guy's took the field with some anxiety with regard to the weather; however, the game was played out with no interference, but on a sodden pitch. Trist and Russell opened the bowling and soon the former succeeded in getting a catch behind the stumps. The Garrison then settled down to steady and stubborn batting. Lunch was taken with the score at 76 for 2.

Following the recommencement, Webb claimed Constable to be l.b.w. and he left for a score of 45. The rest of the batsmen took advantage of the tiring bowlers and each added his quota of runs so that at 4 o'clock our opponents were able to declare at 171 for 9, on a drying wicket and with tea to come at 4.30. This strategy resulted in the two opening batsmen being back in the pavilion in good time for tea with 16 runs on the board. Afterwards, Graham joined Williams and together they retrieved the situation somewhat by steady batting before the captain was bowled for 34. Dyer then came to continue the good work but at 6 o'clock Williams was bowled for 33 and Dyer left soon after for 24 runs, with the score at 128 for 8 but with time to get the runs.

However the remaining men, apart from Billingham, offered no resistance and the last wicket fell at 136.

Russell and Webb bowled 37 overs between them, taking 3 for 62 and 4 for 63 respectively, and Trist bowled well taking 2 for 19 in eight overs.

Scores.—Woolwich Garrison, 179 for 9 declared; Guy's Hospital, 136.

Team.—E. W. Graham, Williams, Trist, Webb, Harvard Davis, Allanby, Dyer, Russell, Billingham, Best, Gillett.

Hospital Information, etc.

Pass List

CONJOINT BOARD.

DIPLOMA IN ANÆSTHETICS.

May, 1946.

F. J. Aumonier G. S. Steele-Perkins
J. H. Capon

Notices

GUY'S HOSPITAL.

JUNIOR STAFF APPOINTMENTS, 1946–1947.

Applications are invited for the following Junior Staff appointments: duties to commence on October 1st, 1946. Applications should be lodged in the Superintendent's Office on or before Saturday, June 29th:—

Assistant Bacteriologist (2); Junior Assistant Bacteriologist (1); Chief Clinical Assistants and Registrars in the Ophthalmological Department (2); Chief Clinical Assistant and Registrar in the Ear, Nose and Throat Department (2); Chief Clinical Assistant in the Dermatological Department (1); Chief Clinical Assistant and Registrar in the Children's Department (whole time, 1); Chief Clinical Assistant and Registrar in the Department of Psychological Medicine (1); Orthopædic Registrar (1); Clinical Assistant to Medical Out-Patients (1); Chief Clinical Assistant in the Radiotherapy Department (1); Clinical Assistant in the Department of Clinical Chemistry (1); Chief Clinical Assistant and Registrar in the Neurological Department (1); Radium Registrar (1); Haematologist to the Hospital (1); Clinical Assistant in the X-Ray Department (3); Assistant Director (female) in the V.D. Department (1); Medical Officers (male) in the V.D. Department (2); Medical Officers (female) in the V.D. Department (2).

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the undermentioned appointments. Duties to commence on October 1st, 1946. Applications should be sent to the Dean, in the Medical School Office, on or before Saturday, June 29th, 1946.

Clinical Tutor in Charge of the Preliminary Clinical Period Class (1); Medical Registrar (1); Acting Medical Registrar (2); Resident Surgical Officer and Registrar (4); Surgical Clinical Tutor (1); Obstetric Registrar (2);

Lecturer in Diseases of the Blood (1); Demonstrator of Pathology (whole-time) (1); Gull Student in Pathology (1); Griffiths' Demonstrator of Pathology (1); Demonstrator of Pathology (part-time) (2); Anderson Demonstrator of Clinical Chemistry (1); Demonstrator of Anatomy (whole-time) (2); Demonstrator of Anatomy (part-time) (2); Demonstrator of Physiology (whole-time) (3); Demonstrator of Chemistry (whole-time) (2); Demonstrator of Physics (whole-time) (2); Demonstrator of Physics (part-time) (1); Demonstrator of Biology (whole-time) (2); Demonstrator of Biology (part-time) (1).

GUY'S HOSPITAL DENTAL SCHOOL.

Applications are invited for the following posts commencing October 1st, 1946 :—

DENTAL MECHANICS AND PROSTHETICS :—Half-time Assistant to Director of Dental Laboratories; 2 Demonstrators for 2 sessions each; 2 Demonstrators for 3 sessions each.

DENTAL SURGERY :—2 Half-time Assistants to Director of Conservation Room; 1 Demonstrator for 1 session; 2 Demonstrators for 2 sessions each; 4 Demonstrators for 3 sessions each; Administrative Dental Officer (half-time).

DENTAL DISEASES OF CHILDREN :—2 Half-time Assistants.

PREVENTIVE DENTISTRY :—2 Half-time Assistants.

DENTAL BACTERIOLOGY :—Assistant Clinical Pathologist (Dental); Demonstrator.

DENTAL HISTOLOGY :—Demonstrator.

MUSEUM :—Assistant to Curator of Dental Section of Museum.

Forms of application may be obtained from the Medical School Office and should be returned on or before Monday, July 1st, 1946.

YORK CLINIC FOR PSYCHOLOGICAL MEDICINE, GUY'S HOSPITAL.

House Officer :—Applications are invited for the position of House Officer in the York Clinic for Psychological Medicine in Guy's Hospital. If the post is filled by a B.2 House Officer, it will carry a salary at the rate of £200 per annum, with provision of board and lodging or an allowance at the rate of £100 per annum in lieu. The post would normally be held for a period of six months. Special consideration will be given to Medical Officers leaving the Services and desirous of obtaining further experience in this branch of medicine, and who may or may not be in receipt of a Post-Services Training Grant. Applications in writing, with the names of two referees, should be submitted to: The Secretary of the York Clinic, Counting House, Guy's Hospital, London, S.E.1.

Applications should reach the Secretary not later than the 15th July, 1946.

SALOMON'S CENTRE.

Applications are invited for the following appointments: duties to commence on October 1st, 1946. Applications to be lodged with the Superintendent on or before Saturday, June 29th :—Dental Officer to Salomon's Centre (1); Anæsthetist to Salomon's Centre (1).

Birthday Honours

AWARDS.

Knighthood.

Major-General Gordon Covell, C.I.E., M.D., Indian Medical Service, Director, Malaria Institute of India, Delhi.

K.B.E.

Acting Air Vice-Marshall John Josias Conybeare, M.C., M.D., F.R.C.P., R.A.F.V.R.

C.B.E. (Civil).

W. Kelsey Fry, M.C., M.R.C.S., L.R.C.P. L.D.S., Dental Surgeon, Guy's Hospital.

M.B.E. (Military).

Flight-Lieut. J. H. Fliteroft, R.A.F.V.R.

M.B.E. (Civil).

Major W. H. Myburgh, South African Medical Corps.

The Services

Mentioned in Dispatches.

In recognition of gallant and distinguished services in Java, 1942 :—

Major (Temp.) H. M. S. G. Beadnell, R.A.M.C.

In recognition of gallant and distinguished services in the Mediterranean Theatre :—

Lt.-Col. A. G. Johnson, R.A.M.C.
Lt.-Col. W. A. Mill, R.A.M.C.
Lt.-Col. L. F. W. Salmon, M.B.E., R.A.M.C.
Major C. H. Greaves, A.D. Corps.
Major A. B. Kettle, R.A.M.C.
Capt. C. L. F. Beaton, R.A.M.C.
Capt. J. M. Munden, R.A.M.C.
Capt. R. T. Parkin.
Capt. S. W. Guilding, A.D. Corps.

Appointments

K. J. Gilchrist, F.R.C.S., Colonial Medical Service, has been appointed Surgeon Specialist to the Fiji Islands.

Change of Address

K. J. Gilchrist, F.R.C.S., Colonial Medical Service, Colonial War Memorial Hospital, Suva, Fiji.

R. F. Pusey, M.R.C.S., B.D.S., 3, Knightsbridge Court, Sloane Street, S.W.1. (Tel.: Sloane 6139.)

J. D. Reinhold, B.M., B.Ch., Tor-Na-Dee, Milltimber, Aberdeenshire.

Marriages

FOLEY—WILSON.—On June 14th, 1946, at Hampstead, John Foley, to Pixie Joy Ann Wilson.

REINHOLD—DALTON.—On June 15th, 1946, at Winchfield, Hants. (quietly), John D. L. Reinhold, B.M., B.Ch., to Jeune Dalton.

Births

TRETHOWAN.—On April 23rd, 1946, in Nuffield House, Guy's Hospital, to Pamela, wife of W. H. Trethowan, Major R.A.M.C.—a second daughter (Sarah Joan).

Deaths

MUNRO WILSON.—On June 9th, 1946, suddenly, at Nuffield House, Guy's Hospital, Donald Munro Wilson, L.D.S., R.C.S. (Eng.), aged 42.

EDS. {R.H.N.L. J.E.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

THE very successful concert given by the Music Club last week was yet another indication, if one were needed, of the re-awakening of interest in activities outside medicine. It is highly desirable that the medical student should explore, not only during his student days but throughout his life, the infinite resources of the worlds of art, of music, of letters and of the theatre. He can, of course, only skim along the surface of these things, since each is a life's work in itself. But maintained as recreations, they provide primarily a means of developing those facets of his personality which cannot find expression in pure medicine or pure surgery, and are moreover a salutary guard against the narrowness of mind which too commonly follows the close pursuit of a single subject.

In any counsel there may be concealed a danger; and here of course the danger lies in allowing these extraneous activities to encroach too far upon the limited time of the student. Since he is a medical student, medicine must have first call upon his time; but it is for the individual student to apportion his time in accordance with his own interests. He will find, during his student days, ample encouragement of his talents; but he must constantly remember that the initiative lies with him. If he would find assistance and co-operation he must set out and find them; they will not come looking for him.

WE are publishing in this issue Dr. Douthwaite's recent Clinical Lecture on "Patent Medicines." It would therefore seem an opportune moment to inform our readers of a truly remarkable preparation now being advertised in India, notice of which has been sent to us by an old Guy's man. This wonderful medicine, this mighty panacea, is guaranteed specific for headache, burning of the eyes, sleeplessness, dandruff, short sight and pains; for cold, deafness, and mental troubles. It will put an end to red spots in the eyes, and is highly efficacious in falling and immature grey hair. Not content with this, the makers have given the remedy itself a fragrance which is most pleasing and attractive.

As our correspondent so rightly observes, beside this, advertisements for British patent medicines would appear almost genuine.

BEFORE the war, any pathological investigation a houseman required out of office hours had to be done by the houseman himself. During the war the same system existed, in theory at least; and recently facilities became more readily available with the return of the clinical pathology laboratory to the top floor of Hunt's House. Now, however, the houseman is no longer faced with the task of estimating a blood urea with the blood in one hand and the instructions in the other. A new appointment has been created, and we have now a junior resident pathologist. It remains to be seen whether our more scientific colleagues will approve of this fresh inducement to forget all our earlier laboratory work. Be that as it may, we feel certain that this innovation will be welcomed not only by the present residents, but also by all their successors.

WE have recently received several contributions which were either anonymous or under a nom-de-plume. We would like to point out that no article or letter can be published unless the Editor is supplied with the name of the author.

THE blue cloth binding cases (with the hospital crest on the front) are now ready, and are available from the *Gazette* Office, price 3*s*. 6*d*. each, postage extra.

GUY'S beat Westminster Hospital in the Semi-final of the Inter-Hospital Cricket Cup by 4 wickets.

Patent Medicines

A Clinical Lecture delivered at Guy's Hospital in January, 1946.

By A. H. DOUTHWAITE, F.R.C.P.

GENTLEMEN,—The passing of the Pharmacy and Medicines Act of 1941 was a belated effort of our rulers to protect the public from a peculiarly rife and cruel form of fraud. Whether it is likely to succeed in this praiseworthy object is a matter you must judge for yourselves. In this I will endeavour to help you by giving a cursory survey of the history of patent and quack remedies.

The origin of patents lies in our early history, and is to be traced to a natural development from the royal practice of conferring some special benefit on a subject for services rendered. This graceful act was broadcast through the country by means of the issue of Letters Patent. In times of war a title and lands were often given for valorous deeds in the field. In more leisurely moments high honours might pass by letters-patent to the king's companions for such services as willingness to marry a tiresome mistress, or a readiness to procure the favours of female relatives for the monarchial pleasures. Thus aristocratic pimping laid the foundation stone of many a stately home. Such affairs were treated as a joke by the ever-tolerant English until James I overstepped the limits by casting letters-patent, and admiring eyes, at the handsome young men of his court. This was too much, and agreement to curtailment of the abuse of royal favours was rung from the King, and control of monopolies passed more and more into the hands of the Ministers of the Crown. Thus emerged the modern grants of Patent Rights.

Now, as applied to drugs, the patent laws afford protection to processes of manufacture or names of the end-product, but there is no provision for the patenting of natural processes, *e.g.*, chemical reactions. As long as the compounding of medicines was in the hands of the physician or apothecary no question of patenting arose. Secret remedies have always been abhorrent to the medical profession. In the last century commercial firms started to enter the field of pharmacy and some, though by no means all, of these concentrated attention on the production of medicines whose manufacturing processes could be patented. The public's welfare in contrast to its gullibility was unimportant. So long as the patent medicine was both harmless and useless, as was almost always the case, its sale was a matter of indifference to the medical fraternity, who have always been tolerant of the foibles of the masses. It was quite another matter, however, when drugs of great therapeutic power were synthesised and kept as a close preserve by being hedged with international patents. Salvarsan, Atophan, Aspirin, Pyramidon to name a few proprietary preparations, were not freed for general manufacture until we went to war with the Germans in 1914. All patent rights of the enemy were automatically cancelled. The recent war provided further freedom of manufacture as of, for instance, Bayer 205 (Suramin). In 1935 it looked as if the Germans were about to scoop the therapeutic market when at long last chemotherapy for bacterial disease was achieved by the production of Prontosil. By great good fortune the human body made short work of the Prontosil patents by breaking down the drug and excreting sulphanilamide. The French, forever on the alert to catch up with their hereditary rival, recognised that therapeutic activity lay in the sulphanilamide and thus presented to the world the first sulphonamide which could be manufactured by all who wished without fear of infringing the patent laws.

It is an astounding fact that no effective legislation had been introduced to check fraudulent claims for patent medicines until 1941. As far back as 1914 a Select Committee of the House of Commons presented a report on Patent Medicines. Unfortunately its appearance followed shortly the outbreak of hostilities and it was not until 1925 that it was published fully, notably in *The Lancet* of that year. At the time of the report a few regulations for protection of the public existed. Thus preparations containing certain toxic drugs had to be labelled *Poison*. It was forbidden to advertise remedies as suitable for abortion, or for the cure of venereal disease. Indecent advertisements were not allowed to be affixed to houses or walls, but there was nothing to prevent circulars being dropped into the basements, from which they would find their way to the servants' hall. Nearly every country in Europe, and all our Dominions, were far ahead of us in these matters, and fraudulent representation was there fraught with peril to the wrongdoer.

True there was the Stamp Duty, originated in 1812 and existing with a revision up to 1941, but this was in no way a protection of the public. It applied to preparations whose formula was not published, but the incidence of the duty was so slight that it could not adversely affect the sales. Furthermore, it applied only if the medicine was alleged to cure an ailment, but not if it was claimed that it brought ease to a part of the body. Thus X's Cough Mixture would pay duty, but X's Chest Mixture would be untaxed ! The Committee's Report makes good and entertaining reading. They pointed out that even for the few regulations governing the sale of drugs there was no official responsible for instituting a prosecution. Especially in relation to fraud, the public prosecutor told them that to take action would be hopeless because of the difficulty of proving intent. For years previously the advertising of quack remedies had been steadily increasing and provided a growing income for the Press—at least two million pounds. Improper advertisements abounded behind a thin veil of selective verbiage. References to relief of diseases " due to excesses " were fully understood by the readers of Home Weeklies for Women, Religious, and Sunday papers in which such advertisements abounded. It was even possible for a purgative manufacturer to suggest that his preparation would *help* in the treatment of venereal disease. The word " help " kept him outside the ban on claiming to treat V.D. Such a public benefactor might reap both honours and millions.

All credit must be given to the B.M.A. for its publication of " Secret Remedies : What they cost and what they contain " (1909), followed by " More Secret Remedies " (1912). It is significant that these volumes received no attention from most newspapers, whose proprietors saw their income threatened by the exposures. Nevertheless, the existence of these publications became known and interest in them spread rapidly throughout the middle-class homes. To combat this, inspired articles appeared attempting to belittle the value of the analyses. It was pointed out that the exact determination of the main ingredients could be granted, but the precise nature of the vegetable matter, which existed no doubt as an impurity, defied analysis. The manufacturers seized on this and stated that the virtue of their nostrums lay in this organic sludge, the secret of which no chemist could reveal ! Of course, the public swallowed the explanation with the same avidity as they swallowed the mixtures. By 1937 the British public, renowned for its sanity and common sense, was paying £20,000,000 yearly for proprietary medicines.

Of the many cases of fraud practised with impunity in this country here are two entertaining examples. There was a Mr. Macaura of America who brought his life-giving vibrator to England. A simple electrical machine which gave indifferent massage was alleged to cure this, that, and the other, and to restore vigour. Whenever there is a hint that a remedy will make old men feel young and give boost to the manly functions of the hitherto frail, there is sure to be a scramble to buy by a host of neurotic impotents and lecherous old goats. Macaura made £60,000 in England and then looked for further fields to conquer. In this he made his first, and possibly last, mistake. He " tried it on " in France. His harvest was three years imprisonment and a heavy fine—an interesting sidelight on the difference of outlook of two nations.

Dr. Derek P. Yonkerman, who " after 20 years of intensive scientific research," produced his Tuberculozyme fared better. He had found the cure of tuberculosis when all had failed. It resided in the administration of copper in a specially prepared form. He was one of the earliest to introduce the personal letter type of advertising. Persuasive literature was sent to hosts of tuberculous patients who paid up to £2 10*s*. for a supply of Tuberculozyme. Once a payment was made they were given no rest. Further supplies and much patience were urged with a certainty of cure. Yonkerman's chemistry was shaky. It is true that traces of copper were found in the mixture in U.S.A., together with bromide, capsicum, alcohol and glycerine. Bulk Tuberculozyme sent to England was found to have no copper. The explanation appears to be that he packed the fluid in iron drums and the Cu. precipitated.

In this country our quacks had a less scientific approach. They often relied on the story of a secret herb given on his death bed by a West African chieftain to the advertiser who had befriended him. In one case the secret herb proved to consist of weeds picked on Wimbledon Common by the advertiser's housekeeper.

Tonic Wines were in great favour here in the first decade of this century. They provided a cloak of respectability to boozing by prim old ladies who often were strong supporters of the temperance movement. Wincarnis, Hall's Wine, and Panopeptone, often earnestly prescribed by the family doctor, contained in those spacious days approximately 20 per cent. alcohol.

The upshot of the Report of the Select Committee was the Proprietary Medicine Bill (1920), introduced in the House of Lords. It sought to abolish fraud and to make obligatory the disclosure of formulae. The latter was hotly opposed on the grounds that it would bring ruin to the manufacturers—a fear which we can see to-day was unfounded. Dissolution of Parliament caused the Bill to be dropped.

In 1934 the Royal College of Surgeons issued a report advising action on the lines recommended by the Select Committee and bringing the sale of medicine and appliances under the control of the M.O.H. The R.C.S. urged that such control should ensure that (1) the proprietary substances were not injurious ; (2) the description of therapeutic action was not fraudulent ; and (3) that no drug be sold with a claim to cure Blindness, Bright's Disease, Cancer, Consumption, Diabetes, Epilepsy, Fits, Locomotor Ataxy, Lupus or Paralysis.

Probably as the result of these recommendations and the public interest aroused, the sluggish conscience of the Government was stirred. In 1936 the Medicine and Surgical Appliances Bill was introduced in the House of Commons with the object of prohibiting the advertising of preparations claiming to cure the diseases I have just mentioned, and adding to the list prohibition of claims, direct or implied for (1) the cure of Amenorrhœa (this, of course, was a smack at abortionists), Hernia, Deafness ; (2) procuring Miscarriage ; (3) the cure of habits associated with sexual excess, or for the promotion of sexual virility in men or of sexual desire in women. The Bill aimed also at prohibiting the publication of invitations to diagnosis or treatment by correspondence.

The suspicion with which our motives are customarily regarded in both Houses of Parliament was shown in the opposition to the Bill, for it was objected that it would restrict unduly the activities of unorthodox practitioners and favour too much the doctors and apothecaries. Such was the interest in public welfare in the House that the Bill was counted out owing to insufficient numbers to constitute a quorum. Once again, therefore, the matter was dropped, but it is to the credit of the British Advertising Association, whose membership included many prominent proprietors of patent medicines, that they voluntarily adopted the recommendations of the Bill and conformed to them.

One must also admit that the drug vendors and advertisers exhibited considerable ingenuity in extending their appeals over a wider and wider field. When, as the result of better social conditions, the bowel habits of the community improved, the sale of purgatives dropped. As a counterblast we were supplied with light music on the air interspersed with talks on concealed constipation. You might defæcate daily, but lassitude, rheumatism and dislike of work were sure signs of accumulated poison in the bowel. The increase of symptoms following the taking of this advice led to yet larger doses of aperients, and the sales soared.

Probably the most ingenious creation of an imaginary disease lay to the credit of a malted milk manufacturer. The pseudo-scientific jargon was so persuasive. Night Starvation ! If the heart and lungs used up energy during sleep no wonder you felt tired in the morning, unless Horlick's were taken at night.

The dismal history of abortive attempts to control fraud ends on a brighter note. In 1941 the National Government found time to pass the Pharmacy and Medicines Act, to which I referred in my opening remarks. The futile Stamp Duty was abolished. The main provisions of this Act are :—(1) Prohibition of advertisements calculated to lead to the use of articles for the treatment of Bright's Disease, Cataract,Diabetes, Epilepsy or Fits, Glaucoma, Locomotor Ataxy, Paralysis or Tuberculosis ; (2) Disclosure of composition. This applies to any substance advertised for the treatment of any human ailment ; (3) Choice of name. Briefly, this section requires the use of official terms in the B.P. or B.P.C. when available. The English, full Latin, or recognised abbreviated form, or synonym may be used. Chemical formulae will not suffice. For substances not included in the official publications, the recognised scientific name must be given ; (4) Statement of quantity. If the substance has an official description, quantity need not be stated. Otherwise the amount of ingredient must be stated on the label as the approximate percentage, or approximate quantity, in each container, or in the case of tablets or powders, the amount in each portion.

The outcome of this Act is that it has given plenty of remunerative work to lawyers, and to doctors and chemists called in to advise firms in relation to their preparations and advertising matter. There is no reason to suppose that it has had the slightest deterrent effect on the sale of patent medicines. Only a minute proportion of the public

would appreciate the significance of the revelation of formulae. For instance, Fluoresc. Solut. 1.5%, Calc. Glucon. 1.0%, Theophyll. 2.0%, and so on, will not help many patients to recognise the nature of an asthma powder, and the precise amount of each constituent needs a wearisome calculation on the basis of a powder-dose of a teaspoonful. In point of fact, before the disclosure of formulae was demanded, many people held back from patent medicines because they feared noxious matter, *e.g.*, tape-worms in anti-obesity tablets ! Now they get the impression of an official blessing from the scientific world as shown by the Latin terms.

I would hazard a guess that the sale of patent medicines will continue to rise. After all no legislation can cope with superstition and stupidity. No orthodoxy can compete with the modern equivalent of the African witch-doctor.

Stockholm, 1946

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ON February 20th of this year four Guy's men embarked for Sweden. As the first British medical students to visit Sweden since 1939 it is felt that some account of our experiences may prove to be of interest. Our stay was relatively short, and it was found impracticable for us all to attempt to see everything. For that reason we approached special departments of which we had heard so much individually ; but we feel that quite a significant field was covered.

Swedish hospitality must be experienced to be credited, and both medical staff and students worked hard to make our visit a success. In the medical world the language difficulty did not bother us, but, nevertheless, we were unable to converse with the patients. Although we returned with widely divergent views on many matters, we were all impressed by the modernity and scrupulous cleanliness of the medical work.

The city of Stockholm (pop. 500,000) has two very large new hospitals, each with accommodation of over a thousand beds. These are the Karolinska Sjukhus (Caroline Hospital) and the Södersjukhus (South Hospital). Another large hospital, the Serafimerlasarett, was built over a hundred years ago and was originally a military hospital. Whilst the Swedes seemed most anxious that it should be pulled down, we could find very little fault with it.

It is impossible here to wander into a long political and economic dissertation. However, certain salient features must be mentioned if only to explain the environment in which modern Swedish medicine finds itself, and to show that facile comparisons are not feasible.

Sweden is approximately twice the size of England, Wales and Scotland. Its terrain, climate and natural resources are completely different, and its population is only 6,000,000. Since 1814 Sweden has enjoyed a period of unbroken peace and is to-day an extremely wealthy country by international standards. For the last twenty years a Socialist government has been in power and to-day the general picture is one of considerable state-ownership and control (including medical services), together with a very high general standard of living. The absence of crime is, perhaps, the best evidence of the lack of poverty, and slums, as we know them, do not exist. In spite of the fact that Sweden is well fed, clothed, housed and enjoys high standards in working conditions, sanitation and public services, it must not be imagined that social disease is lacking. Whilst the maternal and infant mortality figures are very low, tuberculosis, rheumatic fever and anterior poliomyelitis remain as scourges which haunt the community, often more so than in this country.

PUBLIC HEALTH

Tuberculosis.—The tuberculosis mortality per 10,000 in 1937 was eight. In the battle against tuberculosis B.C.G. vaccination has been used throughout Scandinavia for a number of years, and with no disastrous results comparable with the Lübeck incident. In Stockholm mothers are encouraged to bring their children for B.C.G. vaccination and, judging by the numbers who do so, they have considerable confidence in the method. The technique employed is very similar to that used in Jennerian vaccination. The child is first carefully Mantoux-tested. (This is most important, as serious reactions may follow if a positive reactor is vaccinated.) A small quantity of the

B.C.G. suspension is then placed on the cleaned skin and two scratches, just deep enough to draw blood, are made at right-angles to each other. The suspension is then rubbed in for a minute or two. Three weeks later a second Mantoux test is made and, if still negative, a further test is made at six weeks. If this is negative revaccination is carried out. The incidence of tuberculosis in Sweden has been steadily falling for a number of years. This decline has continued since the introduction of vaccination, but there has not been any acceleration which might be attributed to vaccination. Controlled studies on selected groups, however, have shown the method to be effective.

Mass radiography and other weapons play an important part in the anti-tuberculosis campaign. There are also fine sanatoria, and measures are taken to isolate young children who would otherwise be exposed to the disease.

Statens Institutet för Folkhälsan.—This, the central State Institute for Public Health in Sweden, is situated in Stockholm. Apart from the routine work on such things as water-contamination, much interesting research into industrial disease is in progress under the direction of Dr. Ahlmark; the effect of penicillin on air-contaminants; the detection of lead in the urine; and the detection of carbon monoxide poisoning. The latter was a notable feature during the war when petrol was scarce and producer gas was employed on a large scale. The diagnosis of some cases was difficult, and the question of compensation led to the refinement of catalytic methods for the estimation of minute quantities of carbon monoxide in the blood.

HOSPITALS

The Caroline Hospital (Karolinska Sjukhuset) and the South Hospital (Södersjukhuset).—These two new hospitals are situated at opposite ends of Stockholm. The Karolinska Sjukhus was completed shortly before the war and is constructed on the pavilion scheme with separate blocks for each specialty interconnected by a system of roads and underground passages. As the University hospital it is equipped for teaching purposes, but this is confined, of course, to clinical aspects. With over a thousand beds the hospital is spread out over a wide area.

In marked contrast, the Södersjukhus is built in a single block and will accommodate some two thousand in-patients when it is completed. The conception of this hospital was completely worked out by the chief architect, Mr. Cederström, in 1930, but it was only after years of political strife that funds were forthcoming to enable him to start building. He had from the first insisted that an air-raid shelter be tunnelled out of the rock before building proper began. At the time this project was ridiculed, but by some strange trick of fate building actually commenced on September 3rd, 1939. The shelter is deeply placed in solid rock and large enough to accommodate all the patients.

Some idea of the great pains taken in designing the Södersjukhus may be gathered from the fact that representatives of all types of people who would be employed in the hospital came and worked in the architect's office and assisted in the planning in so far as it affected each of them individually. Money was provided for them to study hospitals abroad and to take special courses of instruction if necessary. A full-size model of every room type was built before any plan was fixed, so that the laity should not be misled by architects' drawings. Thus wards, theatres and kitchens were built and displayed to those people who were to use them.

In both hospitals the wards are of a relatively small size, consisting of rooms each with a maximum of six beds. The beds are designed with wheels and the trolley has been dispensed with altogether. Cederström feels that the single block construction of the Södersjukhus presents a marked advantage over the pavilion system from the point of view of administration and co-operation between departments. Furthermore, the Södersjukhus has catering arrangements which are worthy of note. Decentralisation has been aimed at with a view to achieving a closer personal relationship between kitchen and patient. A group kitchen supplies three ward units (about one hundred beds) through smaller kitchens. In this way food is not spoilt by cooking in great bulk, nor do difficulties arise in the transport of cooked food. One man could operate the whole transport system, whereas at the Karolinska Sjukhuset twenty-four men were required for the same task.

Both hospitals are owned and supported by the State in common with all, or nearly all, other Swedish hospitals. A very small nominal charge is made if the patient can afford to pay and private blocks exist in both hospitals. With regard to the latter an extra charge is made for accommodation only, treatment remaining uniform in all respects. This does not prevent the patient from remunerating his physician, however.

NEUROSURGERY

Two of our number attended the neurosurgical clinic at the Serafimer-asarett, under the direction of Professor Herbert Olivecrona. This clinic s one of six neurosurgical units in Sweden. The waiting lists at these clinics are so arge that it is estimated that a person with cerebral tumour may have to wait a year or more before he can be treated. Work commences each morning at 8.30 a.m. in wo well-equipped, modern theatres.

The radiological department of this hospital is under the direction of Professor Lysholm. Excellent work was seen on the localisation of cerebral tumours by diodrast rteriography and oxygen ventriculography. The close co-operation between medical, urgical and radiological departments was remarkable ; and many times conclusions, oth as to the site and nature of the tumours, were seen to be borne out at operation. Microscopical examination of the tumours was frequently carried out in the theatre.

Among the operations seen were aspiration of hypophyseal tumours and the emoval of gliomata and angiomata. Olivecrona removed a meningioma of the falx erebri in two hours, which had previously been beautifully localised by the radiologists. Vestibular nerve section was carried out for Menière's disease, and a vast amount of ympathetic surgery for angina pectoris (the largest series) and other vascular disease vas seen. Some forty-four pinealomata treated by operation with a 17 per cent. uccess-rate is a series of which the clinic is very proud.

At the Södersjukhus, under the direction of Docent Sjöqvist, trigeminal root section nd the removal of a prolapsed intervertebral disc were witnessed. Sjoquist has levised the operation of quinquo-thalamic section for the selective destruction of pain ibres in trigeminal neuralgia.

MIDWIFERY.

The pregnant woman in Sweden is faced with much the same machinery in the orm of a maternity service as exists in England. She attends an ante-natal clinic ased upon her *län* (county), and arrangements are made for her admission to hospital t term. Complicated cases may, of course, be admitted earlier and, although only normal primigravidæ are encouraged to " come in," the vast majority of normal multigravidæ seek admission also. In spite of the fact that an excellent midwives' service exists, domiciliary midwifery is dying a gradual death, the responsibility for which may be laid at the door of the public and not the profession. In December, 1945, one domiciliary delivery took place in the whole of Stockholm and the profession appears to regard this as a regrettable trend.

All normal deliveries (including private cases) are conducted by midwives, except at student training hospitals. The utilisation of anæsthetics has been experimented with, but the feeling of the profession and the apparent trend is against their use. An analgesic machine of gas and air—Karlson's Aga apparatus—is in common use and is very similar to our Minnit's apparatus. Anybody who has trained at Guy's will find a very different *régime* in force in so far as the prevention of sepsis is concerned. The Obstetrical Department of the Karolinska Sjukhus possesses some seventy beds and is divided into a preparation section, a labour section, a puerperal section and a septic section. The preparation section admits the patient, washes her and is the site of a routine examination. The labour section is composed of a number of labour rooms and a theatre. The puerperal section is composed of rooms each containing six beds ; and the patient remains here for only seven days before she is discharged. The septic section is composed of isolation rooms. Visitors, with the exception of husbands, are rigidly restricted, but no attempt is made to check the personnel for carrier infection. Our efforts are, of course, known about and call forth a little wonder and amazement.

At the Karolinska Sjukhus there occur some 2,500 deliveries annually. In the past six years there have been 14,000 deliveries in the obstetrical department with twenty-two deaths. Two of these were due to puerperal sepsis, and one of those was admitted with pyelonephritis. Three deaths were due to eclampsia. Morbidity figures are correspondingly low.

Breast-feeding is naturally encouraged, but where circumstances do not permit it there exists a central organisation known as Mödramjölk Central. This may be regarded as a milk bank, wherein, upon the production of a certificate from a pædia-trician, a mother may purchase human milk at 8s. per litre. Women have been known to amass quite a little fortune by the simple measure of acting as human cows !

KING GUSTAF V's STOCKHOLM JUBILEE CLINIC.

In 1910, equipped with 120 m.g. of radium, Professor Gösta Förssel and his associates commenced the treatment of cancer by irradiation in a furnished flat in Stockholm. This little radiotherapeutic clinic was called the Radiumhemmet (Radium Home). Since then it has grown considerably in size and world importance. In 1913 Professor Ellis Berven joined the staff and is to-day director of the Radiumhemmet; and in 1914 Professor James Heyman undertook to direct the gynæcological work. In 1928 King Gustaf donated the nation's gift to him on his seventith birthday, some 5,000,000 crowns, towards the erection and equipping of a new radiotherapeutic clinic within the precincts of the new University Hospital—the Karolinska Sjukhus. This project was completed and the Jubiliee Clinic inaugurated by King Gustaf in 1938.

To-day the clinic comprises the Radiumhemmet, the Radiopathology Institution and the Radiophysics Institution. One of our number was fortunate in that he lived in the Radiumhemmet for three weeks, and saw something of the gynæcological work carried out by Professor Heyman and his assistants. It is to Professor Heyman that we owe the League of Nation's classification of carcinoma of the cervix, and the evolution of what has become known as the Stockholm technique in the treatment of this condition. In view of the results achieved in this department, the Wertheim operation has now become an historical episode in so far as Sweden is concerned. Carcinoma of the corpus uteri has also passed within the sphere of radium treatment, and a technique developed which is productive of very good results—results at least comparable with those obtained by existing surgical methods.

The Radiumhemmet has to-day somewhat more than 10 gms. of radium element at its disposal, and it provides radiotherapy for the north and eastern two-thirds of Sweden. Lund is the centre for the south and Gothenburg for the west. Patients living within these areas will receive treatment at their appropriate centre, the Government providing the necessary travelling facilities, not only for treatment, but also for periodic "follow up" examinations afterwards.

MEDICAL EDUCATION.

In Sweden the route to medical qualification is uniform, and therefore fairly comprehensible. The issue is not complicated by the coexistence of qualifying diplomas and university degrees.

The student leaves school at the age of eighteen to nineteen, having passed an examination comparable with our Matriculation. Biology is a subject with which he will have already familiarised himself during his earlier years at school. If he proposes entering medicine it is necessary for him to include mathematics, chemistry and physics in this examination. He, or she (there is no barrier to the entrance of women into the profession) may now enter one of the three univeristies in Sweden possessing a Faculty of Medicine. These are Stockholm, on the East coast—the faculty is known as the Karolinska Institut, Uppsala—about fifty miles north of Stockholm, and Lund, in the Southern corner of the country. The cost of the whole course, exclusive of living expenses, books, instruments, etc., is defrayed by the State.

The medical course is divided into two parts. For the first four years the studies are regarded as being "theoretical" and correspond with our pre-clinical studies. The ground covered comprises anatomy (including comparative anatomy), physiology, general pathology and bacteriology, chemistry (not including biochemistry), histology and pharmacology. During the course the student is encouraged to take various posts as student demonstrator, or "assistant" as he is called in Sweden, in one or more of the above. Qualified demonstrators, as we know them, are not in evidence. This is of interest since there is no equivalent of our teaching registrar either. At the end of this time the student sits for what is called the Medicinska Kandidats Examination—the equivalent of our 2nd M.B., and, having passed, becomes officially titled—Medicinska Kandidat.

The student now embarks upon his clinical studies. This period of "practical" training, as it is called, will last some four to five years and, as a result, the average age of qualification is twenty-seven. This probably explains why a greater proportion of students marry before qualification than is the case in this country. Indeed, it is by no means unusual to find a student husband and wife "living in" together during their obstetric appointment.

The first six months of the clinical period is given to "preparatory work." This approximates to our preclinical class and constitutes three months medicine, three

months surgery and includes biochemistry as well. There follows a minor examination and the student then commences his "courses," or appointments, as we would call them. These include a six-monthly period in medicine, six months in surgery, four months in obstetrics and gynæcology, three months in pædiatrics, and then two-monthly periods each in dermatology, E.N.T., special pathology, neurology, psychiatry, social medicine, public health and hygiene, etc. The course ends with two months in special medicine and two in special surgery, when the student assumes the duties of an "assistant"—a student house officer; and, finally, a period devoted to revision before the final examination to qualify as *Medicinska Licenciat*. Many of the shorter "courses" may be combined and the student is free to choose in what order he does them. He is further encouraged to take appointments as student house officer in the country during his training, apart from those already mentioned. Indeed, one student about two-thirds through his course could claim personal surgical credit for thirty appendicectomies and twenty Bassini repair operations!

In so far as the actual medical teaching is concerned, with the exception of obstetrics, the training did not appear to involve the close association between student and patient as is seen at Guy's, in the form of a clerkship or dressership. That does not mean there is an absence of bedside education altogether, but a close relationship is not maintained and the present students are very conscious of a deficiency in this respect. A large proportion of the teaching is conducted by means of the clinical demonstration given by the professor, but it should be remembered that the number of students attending is relatively small. Stockholm, for example, is the largest of the three centres for medical training, and at one time there are only seven hundred students covering the whole nine-year course.

During the whole of the four months period of training in obstetrics, the student "lives in" at one of two maternity centres in Stockholm. Allmänna Barnbördhuset is a maternity hospital catering only for non-paying patients and all deliveries are carried out by students. This hospital accommodates about twenty men and women and the Obstetrical Department at the Karolinska Sjukhus accommodates a similar number. In this way each student will conduct at least forty deliveries during his training.

The medical student is not attached to any particular hospital in Sweden as his counterpart is in England. Besides those hospitals mentioned his course may also carry him to others such as Serafimerlasarettet, Sabbatsberg, Krönprincessan Lovisas Barnsjukhus, etc., Statens Institutet för Folkhälsan (Public Health Institute) and Pathology Departments, as well as the more academic departments of the Karolinska Institut. Furthermore, it is not essential that all his studies be passed at one university. He may, for instance, carry out his pre-clinical studies in Uppsala and complete his clinical period in Stockholm. His qualifying degree will be the same since there is only one qualification.

Mention must be made of specialisation and higher qualifications. Just as there is only one qualifying degree, so there is only one higher qualification. This takes the form of an M.D., necessitates the production of a thesis, and is of a very high standard. In presenting his thesis the candidate must be prepared to defend it point by point since it will be attacked most vigorously by the examining board. In order to become a specialist it is necessary to work as an "assistant" in a hospital for a period of three years in medicine or surgery, as the case may be. In obstetrics and gynæcology three years' surgery and one year obstetrics is the minimum period required. These are minimal figures and are exceeded in the vast majority of cases. To obtain any government appointment after qualification a candidate must have completed a minimum of eight months' work as an "assistant"; but most young doctors will do this, and more, whether they seek a government post or not.

Military Service.—Since there is conscription in Sweden every male student is required to surrender one year and three months to military training. This may be done in parts, some of which necessitate absence from medical studies for a period.

FINLAND.

Whilst in Stockholm two of us were invited by the British Council to visit Helsinki and deliver a lecture to the Finnish physicians and students on some aspects of medicine in England. It was decided to talk on two subjects: "Some Notable Names in the History of Guy's Hospital" and "Medical Education in England To-day."

Our host was Professor Holsti, the professor of Internal Medicine, who entertained us both at the General Hospital and at his home.

At the Radiology Department our party saw some films showing opacities in the lungs of patients with typhus, early in the attack before the appearance of the rash. These opacities are fleeting and must be specificially sought. One film of the chest was of special interest, since it showed the characteristic " ground glass " appearance of asbestosis. Another most convincing film was of a case of prolapsed intervertebral disc, clearly demonstrating the prolapsed nucleus pulposus.

A very common condition in Finland at present is Buerger's disease. One case was only seventeen years old. Another disease of which much is heard is dibothriocephalus infestation, and we were each presented with specimens of the worms to bring back to England. This, however, was probably unnecessary, since after eating the only fish obtainable in Finland—raw sprats—we probably now harbour sufficient numbers of the parasites ourselves.

Tuberculosis is the national scourge of Finland to-day, the mortality rate being seventeen per 10,000. According to Dr. Savonen, who is in charge of the tuberculosis services, the war brought to a halt the declining mortality rate. B.C.G. inoculations are conducted voluntarily on a large scale. Infants are inoculated, where possible, in the obstetric clinics, and special homes are provided to isolate infants from open cases.

At the newly-formed allergy clinic under Dr. Erikson-Lihr active attempts at desensitisation are being carried out for the first time in Finland. At the neuro-psychiatric clinic cases were demonstrated by Dr. von Bagh. Fairly good temporary improvement was claimed for a number of cases of disseminated sclerosis by pyreto-therapy. Pre-frontal leucotomy has recently been introduced in Finland, being used in particular for the treatment of chronic obsessional states. The first case so treated at this hospital was seen after operation, actively engaged in reading a comic paper. Assurance was proffered that the patient could not do this before operation.

" Alcoholic neuritis " is common in Finland, the consumption of wood spirit being high since the people may buy up to one litre per day. This is in marked contrast to the rigid temperance legislation enforced in Sweden.

Professor Holsti initiated the party into the mysteries of the Finnish steam bath. This ritual is widely acclaimed as being responsible for the toughness of the Finns, endowing them with a spirit of unbounded energy and determination ! Many people possess their own steam baths, and the Professor's was situated in a rough wooden shack in his garden. In the corner burned a fire, and water drawn from a near-by trough was cast on to the fire, so that clouds of steam billowed forth into the room. It is the custom to lie outstretched on wooden shelves and perspire freely, and then, when one feels sufficiently relaxed, to run out into the cold snow and roll about in it for a minute or two. This promotes a peripheral vaso-constriction and facilitates drying. We chose to dry ourselves in a more Anglican fashion.

Short visits were made by various members of the party to Krönprincessan Lovisas' Barnsjukhuset (Pædiatric Hospital) in Stockholm, where work on calibrated phono-cardiography was seen ; and also to Copenhagen, where two members were shown round the departments of Professor Meulengracht and Professor Brandsrup. Space does not permit us to detail these and other experiences as we should like to.

CONCLUSION.

Believing serious criticisms and comparisons to be outside the realm of our competency, we have attempted to confine our remarks to fact. The Swedish doctor enjoys a fairly high economic and social status and impressed us with the enthusiasm with which he approached his work. A form of State medical service has existed for many years, and it is now proposed to include private practice within this system and so pay every doctor a set salary. Those members of the profession we met did not seem kindly disposed towards this project.

In closing, we must express our indebtedness and gratitude to all who strove to make our visit a success. In particular, we should like to thank Professors H. Olivecrona and J. Heyman, Drs. Brohman, Ahlmark and Mannheimer, and Docent Sjöqvist, in Stockholm ; Professor Holsti, in Helsinki ; Professors Meulengracht and Brandsrup and Dr. Busch, in Copenhagen ; Lars Hansson, Ake Stenstedt, Arne Aldman and Rune Ordell among the students in Stockholm and Uppsala ; and, finally, to the Dean, Dr. E. R. Boland, for permission to travel.

Obituary

REBECCA FORD.

MANY past Guy's sisters and nurses will remember Sister Rebecca as a familiar figure for a great many years in the Linen Room. Miss Ford began her training at Guy's in 1893 and was appointed Staff Nurse in 1896. Two years later she became a Sister, which appointment she held for 31 years. Although very deaf in her latter years, Sister Rebecca never lost her sense of humour, and always loved a good joke. One of the old school, she believed in discipline and order and her long years of service were marked by utter loyalty and devotion to the interests of the Hospital. She is remembered with affection by many old friends at Guy's. She died recently at Rochford, Essex, at the age of 81 years.

H. M. G.

The Music Club

THE Guy's Hospital Music Club took its first post-war bow on Wednesday evening, June 26th. A chorus and augmented orchestra gave a concert which well earned the tribute of generous applause from an appreciative audience.

In no more than a month Mr. Noel Nickson, the conductor, had fashioned a most adequate chorus from a highly enthusiastic if inexperienced number of singers. True, they were without finesse and poise but for these they made up in the warmth and readiness with which they responded to their conductor's firm and clear-cut intentions. Mr. Nickson demanded discipline and he was not disappointed by either his orchestra or his chorus. With more time at his disposal on future occasions, and we hope there will be many, we may expect Mr. Nickson to have removed some of the rough edges of his charges who show so much promise.

The sopranos and altos, whose quality was good, were a little "parish church" in their pronunciation while the men, as a whole, seemed to lack resonance. We suspected one or two of the tenors of having a mild laryngitis; no doubt the legacy of hard practice. Notwithstanding, the singing was generally robust and balanced, tempo and attack being especially praiseworthy.

The performance began in vigorous style with Bach's Brandenburg Concerto No. 5 in D major. The strings, evidently in good fettle, were off to a good start which they maintained throughout, yet at the same time this enthusiasm did nothing to make them wayward in their obedience either to the score or to Mr. Nickson's baton. They played well. Although Bach probably envisaged a larger number of instruments for his Brandenburgs than for much of his other work, he could hardly have had in mind the Physiological Theatre at Guy's. And it seemed that in that confined space the number of strings made them a little too dominant for the trio of solo instruments.

The flute, violin and pianoforte parts were most creditably performed and Miss Colina Mackenzie at the piano delighted us with her unruffled virtuosity. The "affetuoso" for the three soloists, no easy task, was quite pleasing, and Mr. Baxter and Mr. Ambache who played the flute and violin respectively are to be congratulated.

The final spirited "allegro" flowed smoothly and easily to bring the concerto to an end.

Next, came a group of Liebeslieder by Brahms for voices and piano duet. These the chorus sang well, but so much more could have been done by a better use of expression; of light and shade. Mr. Shave and Mr. Salmon played a sympathetic accompaniment.

The programme ended with a happy choice: Bach's Peasant Cantata. In this the chorus showed itself better able to handle polyphonic music than of the previous kind. The strings were reduced in number but most adequate in their accompaniment.

Although the chorus had had time to warm to their work they must have grown cold in the interval and it was not until latterly that they really showed us of what they were capable. That this was no inconsiderable ability we learned from the choruses, "And now 'tis time to go" and "Now let us to the bagpipes sound."

Even for the experienced soloist, Bach is exacting but Miss Patricia Hicks exhibited great courage in tackling what she must have found difficult. With training and

practise she will make much of a pleasant natural soprano voice. Mr. Donald Munro, the bass, was like the chorus in that he started a little diffidently. By the time he reached his aria "Good fellows be merry" he was singing with gusto and assurance and was greatly appreciated.

The continuo, so important in Bach's works, was splendidly played by Mr. Peter Shave though since he used a piano instead of the harpsichord he rather overdid the spreading of chords in the recitatives with the result that these became a trifle smudged.

And so ended a most enjoyable evening for which the Music Club is heartily to be commended and we hope to hear more from them and their able conductor.

If we may offer one word of advice it is this: The Physiological Theatre, of itself, creates not the atmosphere of the concert hall but rather that of the bathroom. For this reason, a concert there needs so much more window-dressing and despite the lack of clothing coupons evening dress would have made a world of difference to what was a somewhat rustic turn-out however suitable this might have been for the Peasant Cantata. Rehearsals have always been difficult to arrange at times when all are available, but it did seem a pity that the nursing staff was unable to take any part.

Lastly, an unanswered question. Was it inexcusable thoughtlessness on the part of some members of both medical and nursing staffs to have accepted tickets but not used them when so many others applied, but were refused, on account of priority for the staffs? R.T.H.

Review

Local Anæsthesia; Brachial Plexus. By Professor R. R. MACINTOSH and W. W. MUSHIN. Blackwell Scientific Publications, Ltd., Oxford. *Price* 10*s.* 6*d.*

ANALGESIA of the upper limb, by means of a block of the brachial plexus, can on occasions be a most useful method, and one which has perhaps been too little practised at Guy's. This admirable book gives us, in a surprisingly small amount of space, all imaginable information about it. The history of the method, the relevant anatomical facts, the indications, complications and technique, all are fully described, and it is safe to say that, if the instructions given are carefully followed, good results must inevitably follow. If any section of such a useful work is to be singled out for special praise, it is that headed "Local Anæsthetic Solutions," which describes how different drugs, in varying strengths, may be used in order to obtain whatever effect may be required in a particular case. These considerations are only too often overlooked by inexperienced workers, and indifferent results are thereby obtained.

A most distinctive feature of the book is the excellent illustrations, for which Miss M. McLarty is responsible. They convey an extremely realistic impression of the anatomy of the various structures which are in relation to the brachial plexus.

The work is most highly recommended both to young anæsthetists and surgeons, and it is very much to be hoped that the authors will follow it with similar descriptions of other methods of regional analgesia. E. H. R.

(*We regret the delay in publishing the Review of this book.*—ED.)

Correspondence

House Appointments

SIR,—A misleading statement appeared recently in "Passim" which we should like to correct.

A House Officer's knowledge and ability is always of importance to the nursing staff, and these qualities may be the possession of either newly-qualified or returned service men.

The question of relationship with the nursing staff is a third outstanding item. On this point we should not hesitate to say that, with few exceptions, the co-operation and broadened outlook of recently returned service men has considerably calmed the difficult ward environment of the present day.

It has been a gratifying refreshment to see the patients handled as entire human beings, and to be able to have frank and stimulating discussion on them and their

illnesses without meeting barriers so often found in the complexes of newly-qualified men.

We are, etc.,

M. SCALES.
DORIS CHRIMES.
M. DUNCOMBE.

Guy's Hospital, S.E.1.

Plain Speaking

SIR,—Since there has been so much plain speaking in the *Gazette* recently, perhaps the time has come to delete the word " moderate " from the inscription in Nuffield House.

Yours, etc.,

GUY NEELY.

Vernon House,
Lee Road, Blackheath.

Mr. W. King Rist

SIR,—You recently kindly published my letter appealing for subscriptions to a testimonial fund to Mr. W. King Rist on his retirement from his post at Honor Oak Park.

I am glad to say that the response was very gratifying and many old Guy's men contributed. The Club's Union were kind enough to make the figure up to a round sum and I was able recently to send Mr. King Rist a cheque for £50, as a token of the esteem and regard in which he was held by all connected with the Hospital and School.

I wish to thank all contributors for their help in this matter.

Yours sincerely,

W. D. DOHERTY.

10, Upper Wimpole Street, W.1.

SIR,—Mr. Doherty has very kindly sent me a handsome cheque on my departure from my connection with Guy's Hospital Rugby Club.

Can you find space for me to express my thanks to all Guy's men who subscribed so kindly ?

At the same time, may I, through you, give my gratitude to all Guy's men from the highest to the lowest, professional and lay members of your great institution, for 42 years of courtesy and kindness ? Anything I did for Guy's was a pleasure and I look back over that long stretch with the most happy memories.

The first captain I served with was Dr. E. Morgan and my last Mr. Hilliam ; in between were many great players. I have much to think of in my retirement, so much rugger history during those 42 years to think back on and all of it crowded with so much of interest in Hospital Football.

May I add that Mr. Harris, who was groundsman for many years of that period, and Mr. Kirby, who succeeded him, both gave me every help and consideration. I thank them both.

Believe me, Sir,

Yours faithfully,

W. KING RIST.

13a, West Hill,
St. Leonards-on-Sea.

Sport

Cricket

GUY'S *v.* THREE COUNTIES HOSPITAL.

(*Played at Arlesey* (*Beds*) *on Saturday, June 22nd.*)

Lost by 4 wickets.

Guy's won the toss in this all-day game and went into bat at a quarter to one, this late start being due to the deadly efforts of the railway concerned. Munro and Harvard Davis opened confidently, but at 14 Munro was l.b.w., followed by Trist, whose journey to the wicket and back took two minutes. Williams then joined Harvard Davis to bring the score to 46 at the interval, but the most excellent lunch provided had a bad effect on the Guy's batting. Three wickets soon fell, Williams alone being able to consume two portions of gooseberry-pie without playing pudding-like strokes at the wicket: his 55

was a fine innings against very good bowling.

At this stage, Billingham trundled to the crease and, springing from months of lethargic hibernation, proceeded to show the form that once provided Guy's with a very useful dropped goal. Scoring 28 with O'Driscoll at the other end making 20 these two put Guy's in a reasonable position before being all out for 145.

The Guy's bowling was steady and their ground fielding sound, but a mild but perpetual deficiency behind the wicket (needless to say medical duties prevented Allanby from playing) caused Carton-Kelly to return astronomical figures and Guy's to lose the game by 4 wickets.

Scores.—Guy's Hospital, 145 (Williams 55); Three Counties Hospital, 147 for 6.

Team.—E. W. Graham, Williams, Carton-Kelly, Munro, Trist, Harvard Davis, Dyer, O'Driscoll, Allanby, Menzies, Jeffreys.

Fencing

14th May.

GUY'S *v.* LONDON HOSPITAL.
(Won 11—7)

The team got away to a very promising start. London possessed a well-balanced team and the foil bouts were very closely contested. The issue was in doubt right up to the end, but we managed to gain the deciding bout to win the foil by 5 bouts to 4.

In the sabre bouts we established an early lead and held on to it all the way, winning confortably by 6 bouts to 3.

23rd May.

v. KING'S COLLEGE, STRAND.
(Won 11—7)

King's proved to be a rather unorthodox team as far as the foil was concerned. They were fast and very tricky—however, after the initial shock, we settled down to fence more carefully and beat them fairly easily, 6—3.

Their sabre was more effective than their foil, so much so that things looked very black for a time. After some very good fencing by O. F. Conran we managed to scrape through, winning 5 bouts to 4.

29th May.

v. R.A.F., RUISLIP.
(Lost 17—8)

From the beginning the issue was never in doubt. In both sabre and foil we were given a very valuable, not to say pointed, lesson. Such a thorough defeat should prove a stimulus to improvement—for which we have ample room.

13th May.

v. WESTMINSTER HOSPITAL.
(Won 13—5)

A well deserved victory, the team has improved considerably, gaining both in style and self-confidence.

In justice to our opponents, however, many of the bouts involved final point decisions, so that the points scored against us were higher than might be expected from a consideration of the number of bouts against us. (Foil 7—2; Sabre 6—3).

27th June.

v. COMBINED ROYAL DENTAL AND CHARING CROSS HOSPITALS.
(Won 14—2)

Our opponents had not been fencing long, and although they tried very hard indeed they had not the necessary experience or coolness to make any serious threat. The inclusion of two junior members in the team, namely, J. M. Holden and T. Furnivall, was a great success, both men acquitting themselves well.

SUMMARY.

January–July, 1946.

With the loss of Neve and Larsen last Christmas the team almost ceased to exist. However, with the return of O. F. Conran from the Navy, things looked a little better. We had two foil matches against Queen Mary College, London in the Spring, both of which we won 9—7. After this try-out we felt fit enough to tackle some stronger opponents, with the above excellent results.

In general the club has progessed very well, after a very bad period in January, due mainly to an acute weapon shortage. However, with the addition of several new foils and sabres the attendance at practices began to increase, and now the keenness of members is beyond reproach. In conclusion, I should like to thank members for their support and the keenness they have shown, which I think augurs well for the future of this club.

N. H. PORTER.
(Captain).

Hospital Information, etc.

Change of Address

Peter Bishop, M.D., 122, Harley Street, W.1, and The Warden's House, Guy's Hospital, S.E.1 (Residence). (Tel.: Hop 1177 for both addresses.)

Miss M. Butler, Park Hospital, Manchester.

J. R. Forbes, M.D., M.R.C.P., 25, Trinity Church Square, S.E.1. (Tel.: Hop 0848.)

S. R. Trick, O.B.E., M.B., B.S., Hartwell, 5, St. Gregory's Road, Stratford-on-Avon.

Papers by Guy's Men

Stephens, H. Freize. Research in mental deficiency. *Lancet*, 1946, i, 623.

Harley, R. H. S., and Others. The pathogenicity of penicillin and insensitive infection. *Brit. Med. J.*, 1946, i, 639.

Rewell, R. E. Carcinoma of the rectum in sisters. *Ibid.*, 683.

Spalding, J. E. Fowler's position. *Lancet*, 1946, i, 643.

Clarkson, Patrick, and Another. The management and surgical resurfacing of serious burns. *Brit. J. Surg.*, 1946, **33**, 311.

Randall, K. J., and Spalding, J. E. Simultaneous carcinoma and tuberculosis of the colon. *Ibid.*, 372.

Births

BURN.—On May 22nd, 1946, at Guy's Hospital, to Peggy (*nee* Bird), wife of R. R. Burn, Capt. R.A.M.C.—a daughter (Ann Margaret).

BRITTAIN.—On May 13th, 1946, in Allington House Nursing Home, Ipswich, to Honor, wife of R. G. L. Brittain, Surg.-Lt. The Life Guards—a son.

EDS. {R.H.N.L. J.E.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

IT has been said that the whole structure of the Medical Profession is based upon the fact that doctors do not advertise. This, of course, is absurd. All doctors advertise. And yet we are certain that the doctor who advertises himself most would be the first to throw up his hands in horror at the mere suggestion that he could even remotely countenance such an outrage. He would probably make some trite little remark about medical etiquette, allude rather bitterly to the G.M.C. and promptly rush off to see whether the arum lilies in the waiting-room were quite as fresh as they should be.

So far as we know no doctor has ever advertised himself by sticking up a bill on a hoarding. One so adventurous would be afforded ample opportunity to reflect upon the best way of living down the reputation he had so painstakingly built up, and the South American continent, we believe, is not unpopular with those so peculiarly constituted. No, nothing so blatant or so commonplace or, indeed, so utterly fatal as a hoarding has ever been contemplated or, to be more precise, actually utilised. It is the polished car (several horse-power more than the pocket will fully allow), the apparently busy secretary furiously tapping out letters to proprietors of patent pills, the uniformed nurse opening the front door, the thick plush carpet in the consulting-room and the cunningly shaded little table lamp (which shines on the patient and leaves the doctor rather romantically in the shadows), it is these, with variations on the same theme, which do the advertising, if only a small part of it.

Unquestionably, in our opinion, the doctor's best advertisement is his wife, if he is fortunate enough to possess one, but not someone else's, if he isn't. The doctor's wife is a woman of great importance. Even now, perhaps, she is on holiday with her husband and children, enjoying a well-earned rest and conducting herself with one eye on her husband's career and the other on her beach pyjamas, for the latter must excite no comment which could affect the former.

We need not discuss her many obligations and her duties in the home. These are either too well known or can be imagined. When all the people in the district where her husband practices declare, spontaneously, "I shall consult Dr. So-and-so, for he has *such* a charming wife," she may rest assured that she is a very satisfactory wife for a doctor to have. One of the hardest of her tasks, surely, is to continue to be friendly with all the ladies who think they have fallen in love with her husband. She may know perfectly well that one of them has a large photograph of him on the grand piano; and yet the very most she can do is to hope that it will topple off and break during the Spring cleaning.

We know how wonderful a doctor's wife can be and, while paying her this small tribute, we wish all Guy's men and their wives and their children a very happy summer holiday. And if there are any young Guy's men who find it difficult to acquire a reputation, in spite of the subtleties outlined in our second paragraph, perhaps they would find it easier if they acquired a wife.

WE have much pleasure in announcing that Mr. W. D. Doherty has been appointed Deputy Superintendent of the Hospital.

SISTER TAYLOR and Sister Scales had the honour to be invited to Their Majesties' Garden Party at Buckingham Palace, which they attended on Tuesday, July 9th. Sister Taylor was presented to The Queen, who again showed her keen interest in the welfare of the Hospital.

A NEW edition of the Clubs' Union Handbook is now available to members at the Medical School Office. This book, which has been out of print for some time, contains a great deal of information about the constituent institutions, and members of the Clubs' Union would be well advised to obtain a copy.

THE Directory of Guy's Men has now been sent to all those entitled to receive one. There are, however, a few copies still available, and these may be obtained at the *Gazette* Office, price 5*s*. each, postage 3*d*.

A Case of Post-Hæmorrhagic Blindness

Presented by C. P. MILLS

(with the kind permission of Dr. Marshall)

THE rarity of this most distressing condition warrants its publication and, at the same time, may stimulate opinions as to its ætiology and possible treatment.

Case history.—Mr. N., aged 60 years, a baker, was admitted to Guy's under Dr. Marshall on August 17th, 1945.

The patient who had been perfectly well, and with excellent eye-sight, had a sudden attack of faintness and palpitations with headache. The following day he vomited about one pint of dark red blood, and again three days later he had a further hæmatemesis.

Neither on this occasion, nor at any time previous to this, had he noticed any abnormal colouration of his motions. Very shortly after his second hæmatemesis he noticed that his vision was becoming blurred, more especially in the right eye. He described it as though he were looking down a tunnel.

The palpitations and headache became more severe.

Condition on admission.—The patient was in a collapsed condition, very pale and breathless, and sweating profusely.

On Examination.—There was slight tenderness in the epigastrium with no guarding.

Rectal examination showed a small amount of dark blood on the finger-stall, otherwise nothing abnormal could be found.

Both pupils reacted only sluggishly to light, the right pupil being markedly dilated. There was concentric narrowing of both visual fields, and vision was limited to two feet for gross objects. Both discs showed early papillœdema. Slight congestion of the retinal veins was apparent in the right eye, and there was marked narrowing of the retinal arteries in both eyes.

His jerks and cranial nerves were normal.

Pulse, 80; frequent extra systoles. Blood pressure, 110/60.

Investigations on admission.—Urine normal. Hæmoglobin, 20 per cent.

X-ray of chest showed chronic bronchitis.

Treatment.—The patient was put on a Duodenal Ulcer diet.

He was transfused with one pint of fresh blood, and subsequently treated with Iron and Ammonium Citrate.

Progress and subsequent investigation.—August 20th: A fæcal specimen was taken for occult blood which gave a strongly positive guaiac reaction, and well-marked hæmatin and hæmatoporphyrin were present.

August 24th: Fæcal specimen was free from occult blood, and remained so up to his discharge.

At this time the patient still looked very ill, but had no temperature. There had been no improvement in his vision.

August 31st: Hæmoglobin 55%. His eyesight was not quite so blurred but he still complained of the tunnel vision.

September 3rd: Test meal showed very slight hyperchlorhydria with no delay in emptying.

September 6th: Barium meal and enema showed no abnormality. Kahn and Wasserman reaction were both negative.

The patient got up for a short time.

September 18th: Hæmoglobin, 80%. There was no change in his visual defects.

September 28th: The patient was discharged with no gastro-intestinal symptoms, but with marked impairment of vision.

Discussion.—In the case described, visual defects did not come on immediately following the last severe hæmorrhage. In other cases, reported in various papers, this has come on immediately, or, as in a case of Sir Adolphe Abrahams', it appeared 22 days after the last hæmatemesis.

It is improbable that one massive hæmorrhage of itself causes the blindness, but is the precipitating factor, following long continued hæmorrhages.

A case described by Rugg-Gunn serves to illustrate this point. A girl aged 18 years had suffered from metrorrhagia ever since the onset of menstruation; ultimately menstrual function was abolished by the application of radium. Seen soon after a severe uterine hæmorrhage, she showed great pallor, and complained of blindness which had developed 24 hours earlier.

Both eyes are not necessarily affected equally, or at the same time.

Cases have been described in which the onset of blindness in one eye has been followed, as much as nine days later, by blindness in the other.

There is Black's case of a man aged 53 years who was admitted to hospital on August 18th. During the preceding three weeks he had suffered from lassitude and anorexia and occasional dull epigastric pain after meals. He had noticed a little blood in his stools prior to this, but his sight had always been good.

August 13th: He vomited about a pint of bright red blood. Soon afterwards he passed a tarry motion, which was followed by another hæmatemesis.

August 16th: He woke to find he was completely blind in the left eye, and only appreciated hand movements with his right eye. Within a further 15 minutes his right eye was completely blind.

Fries collected 106 cases of post-hæmorrhage visual defects, and gives 25 per cent as the proportion that occur during or immediately after the hæmorrhage.

It might be thought that if hæmorrhage were the only factor in causing these visual defects, then more cases would have been reported from the various battle-fields. In the 1914–18 war not one case was reported.

Terrien suggests that the optic atrophy is due to two things: (1) Hæmorrhage; (2) An associated toxæmia. This theory may be supported by the case of a French soldier who had been wounded by a shell, and lay in the battlefield for four days unattended; he subsequently developed gas gangerene in his limbs, followed by blindness in both eyes.

Numerous theories have been advanced in an attempt to explain the cause of this condition.

In 1904 Samelsohn, quoted by Gowers, considered that the nervous connexions between the stomach and the corpora quadrigemina afforded the best explanation, it having been noted that injury to the corpora could give rise to hæmatemesis.

In 1920, Goerlitz examined an eye pathologically 10 days after the onset of blindness following hæmatemesis; the main changes found were intense œdema of the disc and the retina, these changes resembling those found in amblyopia such as is caused by methyl alcohol.

In 1929, Whiting read a paper to the Opthalmological Society of the United Kingdom in which he described five cases of post-hæmorrhagic blindness. In the following discussion he appeared to favour the hypothesis that toxæmia renders the ganglion

cells more sensitive to blood deprivation and that sudden death of the ganglion cells and their fibres is responsible for the blindness.

Wolff, quoted by Rugg-Gunn, suggested that diminished oxygen supply might lead to spasm of the arterial wall, and so be the cause of blindness.

Minton states that in all cases optic atrophy, with very narrow retinal arteries, is the final late result.

This opthalmoscopic picture is so similar to the one seen in the case of occlusion of the artery of the retina due to thrombosis or embolism of the retinal arteries that one is led to conclude that sudden spasm of the retinal artery followed by thrombosis is probably the most common cause of post-hæmorrhagic blindness.

With all these theories, one is still at a loss to know the exact ætiology of the condition.

There are certain clinical signs that are common in nearly all cases.

The hæmoglobin percentage is always low, in one case it reached 15%, and in no cases has it been higher than 45%.

The normal red cell count is at least halved. Another interesting feature is that the systolic blood pressure is very low, even down to 80 m.m. mercury. Initially the pupils are dilated and react very sluggishly to light, and as the blindness progresses they become quite unreactive.

Papillœdema of the discs of varying dioptres of swelling, and œdema of the retina is always seen in the early stages. The disc later becomes very pale.

Retinal hæmorrhages are fairly common. Seen early the retinal veins are markedly dilated and the retinal arteries constricted.

Spasm of the retinal artery followed by a thrombosis is the most attractive theory as to the causation of post-hæmorrhagic blindness, but this has not been conclusively proved.

The following table will give some indication as to the sex incidence, age, and site of hæmorrhage, of the 14 cases reviewed above :—

	No. of cases
Male	12
Female	2
Intestinal Hæmorrhage	13
Uterine Hæmorrhage	1
Age—15–40 years	4
40 years and above	10
Onset in one eye	9
Onset in both eyes	5

It will be seen that most cases are male and over the age of 40, also more cases have the onset in one eye first, followed by the other at any interval up to nine days.

SUMMARY.

The details of a case of post-hæmorrhagic blindness have been given.

The literature on this subject has been very briefly reviewed.

REFERENCES.

Sir Adolphe Abrahms, *Brit. Med. J.*, Jan. 12 (1946). Rugg-Gunn. *Proc. Roy. Soc. Med.*, **31**, 665 (1937–38). Black, *Brit. Med. J.*, Dec. 29 (1945).

Gowers. *Medical Opthalmology.*

Whiting. *Trans. Opthal. Soc., U.K.*, **49**, 144 (1929).

Minton. *Brit. Med. J.*, Feb. 2 (1946).

A Tour of the United States Plastic Surgery Centres

By PATRICK CLARKSON, M.B.E., M.B., B.S., F.R.C.S.

PART III

THE last few weeks of my tour were spent between Toronto, Boston and New York. It had been my good fortune on my first visit to New York to meet Dr. Fulton Risdon, the Canadian Consultant in Plastic Surgery, and through him I had been invited to visit the Canadian Veterans' Hospital at Christie Street, Toronto. At the Plastic Centre of this Hospital, Dr. Risdon works with Dr. Stuart Gordon and Dr. Farmer. Christie Street is an extremely busy Centre, just as, of course, Toronto, where Dr. Gallie is Professor of Surgery, is an extremely active medical centre in every respect. I had much too short a time there to see more than a small proportion of the work. Even with my chief interest a speciality such as Plastic Surgery, it was only possible to see samples of the work in that field in Toronto, at the Christie Street, the Toronto General, the Western, and the Children's Hospitals.

Dr. Stuart Gordon's work with medullary chip bone grafts for the repair of bone gaps in jaw wounds, and for skull defects, is well known. I was particularly interested in having the opportunity of examining one massive skull defect of the frontal region which he had repaired by this method over a year ago. The repair was bony hard to palpation, appreciable late absorption had not occurred, and contour restoration was exact. It is a tendency to late absorption and flattening which is the disadvantage of the medullary chip method, which as a repair by living tissue would otherwise be preferred to repairs by any foreign material Dr. Gordon's interest in the medullary chip method includes experimental work and he has a series of sections of experimental medullary grafts which indicate that only very little of these chips is incorporated in the body from the start as living tissue (in the way a twig is grafted to a tree and as was at first believed). The greater part of the medullary chips is absorbed by osteoclasts which stream out from the medulla and periosteum of the freshened recipient site, and is rapidly replaced by new bone.

Snow had grounded all planes, so I did the journey from Toronto to Boston by train. My first calls in Boston were on Colonel E. Churchill and Dr. V. D. Kazanjian. Colonel Churchill is now back in the Harvard Chair of Surgery at Massachusetts General Hospital, having for the last three years been Consulting Surgeon to M.T.O.U.S.A., where, as all who worked in that Theatre know, his beneficial influence was widely felt in all the Allied Armies. Dr. Kazanjian, who does the plastic surgery at the Massachusetts General Hospital, will be well remembered in Britain for his work in France with the Harvard Red Cross Unit for the British face and jaw casualties of the last war. It was this work which established the fundamental principles of fixation of the facial skeleton in open jaw wounds.

In the Surgical Service at M.G.H., a very wide range of medical activity is in progress and I have to thank Colonel Churchill for giving me access to every aspect of it. Of special interest to me was the work there in different aspects of the burns problem. In Boston this interest in burns was given a great impetus on the occasion of the Coconut Grove disaster five years ago. The burns work at M.G.H. comes under Dr. Oliver Cope, section of Metabolic Surgery. One profitable line of investigation is in the use of Radio-active sodium to follow the distribution of œdema and the mechanism of fluid loss in burns. These studies indicate that the fluid lost from the circulatory system may be the same, whether 15 or 75 per cent. of the body is affected by the burn. If this is so, fluid replacement therapy in serious burns should be independent of the area involved. The previous policy of making the amount of plasma given proportional to the involved area may therefore not be right, and present policy is to give all cases of over 15 per cent. body area burns a standard infusion of an eighth of the body weight of plasma in the first 24 hours. Very great importance is attached to maintaining the blood pressure in the early stages, as it is thought probable that anoxia of the renal epithelium in the first eight hours can cause irreversible renal damage in severe burns. A check on the rate at which fluid by vein should be administered is afforded by an indwelling catheter in the bladder. Enough intra-

venous fluid should be given to maintain a urinary excretion of at least 20 cc. an hour.

Other studies in the circulatory volume and in lymphatic pressures in burnt animals indicate that local compression of the burn may in fact not be completely effective in preventing loss of fluid from the circulatory system, and that œdema prevented by local compression may appear in proximal uncompressed parts of the body.

The programme of treatment at the M.G.H. for extensive burns with full thickness skin loss is sometimes very radical. It consists of early (three to five days) excision of dead skin and replacement by dermatone grafts. In one case which was treated, whose colour photos I was shown, the replacement grafts consisted of eight full dermatone drums (over 1,500 square centimetres). Such treatment is only possible with transfusion and anæsthetic services of the highest order.

I was present at another demonstration of the section of Metabolic Surgery. This was a case of carcinoma of the thyroid with secondaries in the spine. These secondaries were being treated by radio-active iodine (after thyroidectomy). The case was shown and the presence of the radio-active iodine was in high concentration in the secondary spinal deposits was shown by the vigorous positive reactions of the radio-sensitive instrument held close to the spine.

Specialisation in Metabolic Surgery was new to me. It is an interesting and fruitful line of cleavage from the general block and as far as I could see at M.G.H., it comprises thyroids, para-thyroids, thymus, adrenals and male gonads. The surgeon doing it has a particularly strong liaison with the Physiology Department, both Biochemical and Endocrine. By confining his clinical work to this field he is assured a sufficiently concentrated experience, and can too keep abreast of all new work in this complex subject.

While in Boston I paid frequent visits to the theatres of Dr. Kazanjian, whose work in the reconstruction and remodelling of noses is widely recognised throughout the States. In these operations, he has a variety of techniques which are all his own. He has too a very complete collection of case records and photos of the jaw wounds of the last war. It was my good fortune to spend several most instructive hours with him studying these records and comparing these cases and their treatment with similar casualties of World War II. It is doubtful if the clinical picture seen in any other group of casualties on arrival at Base in the two wars has differed so radically. In the last two years of World War II early surgery and primary repair of the face wound caused the complete disappearance of the old clinical picture of the jaw wound with unfixed fragments, attended by a diffuse cervico-facial cellulitis, with a drooling fistula and foetor.

During this visit to Boston, I met Dr. Robert Osgood, who worked with Sir Robert Jones in the Great War. He sent messages to his many friends in Britain. It was, too, a very great pleasure to meet at the Harvard Club the Maxillo-Facial Unit of the U.S. Army, Col. Langdon Parsons and Major Clark, who had been sited about a mile from us in Naples. Throughout our work in Italy we had independently adopted a very similar attitude to our clinical problems and evolved very similar operative techniques in facial repairs.

From Boston I went to New York to await the sailing of the Queen Mary, and there spent my time chiefly in the clinics of Dr. Jerome Webster and Dr. Gustav Aufricht. Dr. Webster is Consulting Plastic Surgeon to the U.S. Army. He works at the Presbyterian Hospital, Columbia Medical Centre, Washington Avenue, where a very wide range of major reconstruction problems is to be seen. Dr. Webster's influence is very apparent in the wards of his pupils who are in charge of plastic centres in the Army and Navy. It stands for meticulous craftsmanship and acceptance only of the highest possible standard of end result in facial repairs as well as in those repairs of body wounds done in conjunction with orthopædic and peripheral nerve surgeons. His Registrar, Dr. Clifford, will be remembered from Tunisia as U.S. Liaison Officer to Brigadier Wade with the First Army. Dr. Aufricht works at the Post-Graduate Hospital, and there demonstrated to me a number of facial repairs of excisions done for malignancy. He enjoys too a very special reputation in the more cosmetic realms of plastic surgery, and was most kind in his demonstrations of the technique and planning of these operations. It is, perhaps, a little paradoxical that of all aspects of plastic surgery it is in cosmetic operations that the quality of the surgery has to be most uniformly meticulous if good results are to be obtained.

Another interest in these last days in New York was the study of the use of heavy cosmetics in Plastic Surgery, and I visitied the establishment of Miss Lydia O'Leary,

whose cosmetics have very special value in the disguise of birthmarks. They need only one application a day, are non-irritant over a period of years. My general feeling about cosmetics and plastic surgery was that (like tattoo, which I had had the opportunity of studying from a clinical point of view at Valley Forge) they were a most valuable adjunct to surgery, but could not disguise the uneven contours of heavy facial scarring, or redeem a bad surgical result.

In retrospect and in review of Surgery in America as seen on this tour, my predominant impression is one of admiration for the successful way in which they have integrated the work of many specialists, and have thus avoided the classical pitfalls of a super specialisation while at the same time attaining a higher standard than is possible in a purely general approach to the multiple and complex problems of modern surgery. It is a system which in the last few years has yielded such results as Dr. Blalock's excision of the thymus for myasthenia gravis; Dr. Blalock's anastamosis of the innominate to the pulmonary artery for the relief of congenital pulmonary stenosis in babies; Dr. Ladd's successful closure of congenital tracheo-œsophageal fistulae in babies; Dr. Ladd's successful operative relief of congenital tracheal stricture; Dr. Dandy's successful excisions of congenital intracranial berry-aneurysm; Dr. Dandy's surgical relief of combined intracranial and scalp cirsoids; Dr. Blakemore's work in veno-vitallium vessel anastamosis; Dr. Gross's surgical relief of co-arctation of the aorta. Along with other contributions they make American surgery a stimulus and a challenge to all other countries.

It is perhaps permissible to enquire what the leading differences between the American and European medical systems are. One that immediately stands out as of increasing importance is the enormous matériel (in the French sense) available for medicine in the States to-day. The way in which atomic energy is already being applied to medical problems is an example of this. It seems to me, too, that medicine in the United States can command a greater proportion of the financial wealth of the country than is available to us and some other countries, and this is associated also with a very high domestic authority of the profession. (It is probably true that most Americans if asked "What is the way you can do most good?" would still answer, "by being a doctor"). On the educational side, there seems to be a tendency in some clinics for people who are the directors, or are training to become the directors, of surgical clinics, to do a number of registrarships in the different specialities rather than to do one long general surgical registrarship. This early experience in several specialities is to equip the surgeon to direct a professional unit in which the work of many departments must be co-ordinated, rather than to enable him to practise a wide range of surgery. The actual clinical work of these general surgical chiefs tends to be as narrow as that of any of the traditional specialities. It may be vascular surgery, chest surgery, upper abdominal surgery, metabolic surgery, or one of the traditional specialities. Whatever it is, the surgeon is assured a sufficiently concentrated experience in his line for him to make contributions of importance in his subject, if he has it in him. He is, therefore, a general surgeon by his training and varied early experience and in his administrative and educational responsibilities, but a specialist in his actual clinical work. Such a system of training appears an acceptable solution to the objections of increasing specialisation in surgery, provided the patients are treated at big medical centres, as in a country with modern communications they increasingly are. On the other hand, in medicine it would seem that there must always remain a role for the truly general physician, practicing as such. It may be further asked to what extent is the Sydenham tradition or the "Continental system" prevalent in American medical practice to-day. By "Continental system" I mean the method of mass investigation of medical problems, as opposed to a personal approach to each patient with treatment based upon the individual needs of each case. Both trends can be seen in American medicine (as they can in English). A dilemma of medicine to-day is that most modern advances are derived from investigations based on a "Continental" approach, but that the best doctors remain disciples of Sydenham.

Conversations, particularly in Boston, concerning post-graduate medical education, brought up an interesting prospect. It is that all over the world, from Europe, from China, from South America, and from India, doctors will be looking outside their own country for their post-graduate education. They must look either to the United States or the U.K. This prompts the observation that at most hospitals facilities for post-graduate education are quite neglected. There is even indeed a general bias to be found against sparing the space or the time from under-graduate education. Such a view is no longer tenable to-day when the nature of medicine makes the post-

graduate aspect of education of increasing importance, and a nearly equal responsibility to a Medical School, if it is not to find much of its influence and its old role usurped by new post-graduate institutions. There is the other important aspect of post-graduate education which concerns the increasing role which medicine is playing in international relations and contacts. To some extent, it has succeeded in this respect some of the ancient international functions of the Church. For example, few sections of the English speaking world—the U.K., the Dominions, the U.S.—are in closer communication or contact with each other than the medical professions in these countries. In addition to the obvious opportunities for international contacts which post-graduate centres increasingly provide, other examples of international medicine are provided by the British-Argentine Medical Centre of which Dr. Castro O'Connor is secretary in Buenos Aires, and by such as the U.N.R.R.A. Plastic Unit in Yugoslavia. The work of this Unit, which was placed in Belgrade on the advice of Sir Harold Gillies, in providing the Yugoslavs with surgical services otherwise unobtainable has won the strong approbation of Marshall Tito and the goodwill of the Yugoslavs at a time when Western influence in the Balkans has been much reduced.

It was refreshing too to find in Boston a vigorous belief that problems of medical service and specialist care which in many countries it is claimed can only be solved by State control, involving surrender of personal liberties, can in fact be solved by extensions of personal medical insurance schemes which preserve the ancient patient-doctor relationship. So used is one to the contrary belief that I was even more startled than delighted to hear the view that it is the weaker brethren in the profession who turn to administration and State medicine because they find clinical work and the responsibilities of being the exclusive servant of the patient's interests too exacting.

Concluded.

(This is the last of three articles on this subject which have been published during the last two months.)

Sonnet to Keats

On visiting Wentworth Place, Hampstead—22nd October, 1945.

Keats ! Never pilgrim came to poet's shrine
Intent as I to yours, when Autumn's brush
Painted the leaves gold and incarnadine
About your tree-girt home. There fell a hush
As watchful Nature held her breath suspended,
Jealous to guard against profanity
The floors I trod ; and when my roaming ended
I felt your haunting presence press on me,
Still lingering on your doorstep while the clock
Ticked a full minute. Loth was I to leave,
Lulled by such shadow-shapes as dreaming sets
Before the helpless sleep-sunk mind to mock
Cold truth—The minute fled—Again I grieve
Your dust beneath the Roman violets—

E. A. PENNY.

Correspondence

House Appointments

LIMITATION of space prevents the publication of any further letters on this subject for the time being. We feel that every aspect of this problem has now been fairly well covered, and thank all those who have contributed to the lively discussion and expressed their views so frankly.—ED.

The Heraldry of Guy's Hospital

By KENNETH HOOPER, M.R.C.S., L.R.C.P., L.D.S. R.C.S.

HERALDRY is as popular to-day as it has ever been and is more correctly used than for some generations past. It is associated with the age of chivalry when knights and men in armour needed to mark their identity in battle or the tilt yard. The art dates back to very much earlier times. Flags and banners are the province of heraldry. We read of the Lion of Judah in the Old Testament, which must have been a heraldic device.

The right to bear arms in England was most jealously guarded by the barons and was under the supervision of the Earl Marshall, now the hereditary title of the Dukes of Norfolk. Those entitled to armorial bearings had them carved on their buildings, a good example of early work being seen over the entrance gate of Bodiam Castle, and painted or engraved on their possessions. With more peaceful and prosperous times individuals assumed arms, and by the sixteenth century heraldry in this country was in a somewhat chaotic state, since a large proportion of armorial bearings were unauthorised and unrecorded. During this century the heralds made a systematic visitation of all counties, and registered and recorded all arms being used at that time; from then on any arms used had to be granted by the Earl Marshall and the officials of the College of Arms.

This has not prevented many families, colleges and boroughs from assuming arms to which they were not entitled. With recent increased interest in the subject this has led to investigations by the parties concerned and to the registration of their arms, with proper differencing, by a number of colleges and boroughs during this century.

Armorial bearings consist of a shield, sometimes called an escutcheon, and a crest which is borne on the top of the helmet. These two should be absolutely unique to the individual. The shield must differ in two respects from any other recorded shield. This is not difficult for heraldic artists, for so many designs are possible. Some crests, however, are practically identical. A motto is included in the grant and may be of any length and need not be peculiar to a particular grant.

An additional honour are supporters, which are figures shown on either side of the shield guarding it, as the lion and the unicorn on the Royal Coat of Arms. These are usually only granted to Peers of the Realm, Knights Grand Cross of an order of Chivalry or to County Boroughs.

The grant of arms used by Guy's Hospital was taken out by the Executors of Thomas Guy in the year 1725.

"Sable on a cheviron or between three leopards' heads argent each crowned with an eastern crown of the second as many Flowers de Lis azure and for a crest upon a wreath of the colours of the field. A woman sitting accompanied with three children proper habited azure being the emblem of Charity, the arms supported on either side by an Angell proper habitted argent the hair and wings or each holding a book proper the clasps gold and underneath the following motto: *Dare quam accipere.* As in the hereof the same are more plainly depicted to be borne and used for ever by the said Corporation and that the arms crest and motto may be sett upon the monument designed to be erected to the memory of the said Thomas Guy."

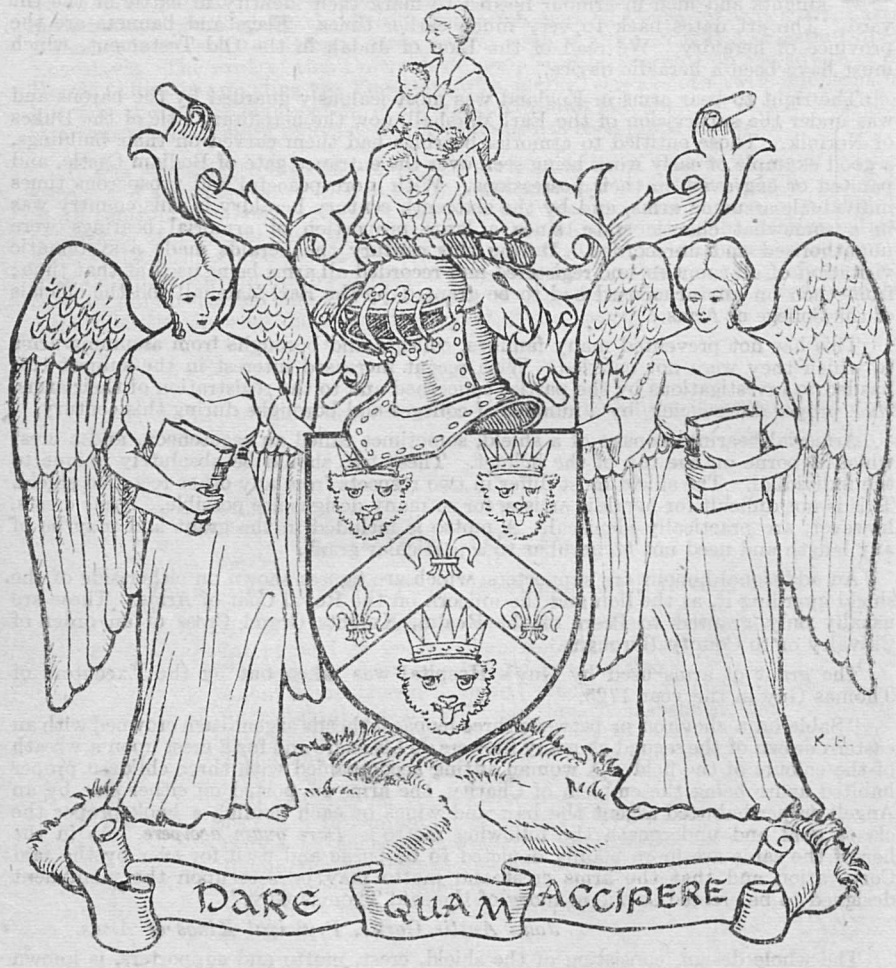
John Austis, Garter, Principal Kings of Arms.

The whole design, consisting of the shield, crest, motto and supporters, is known as the achievement.

The original grant of arms to the Hospital hung in the old Counting House, which was burned out in 1941. It had, however, been sent down to the country and escaped destruction and is now back again hanging in the Hospital.

The achievement is splendidly shown over the entrance gates in St. Thomas Street. The work is carried out in lead and is very good heraldry. The figures of the supporting angels are beautifully modelled. With this excellent example of heraldry before their eyes it is surprising that the debased presentation of their armorial bearings at present in use at Guy's should have been tolerated by so many generations of Guy's men.

I have drawn out the arms granted to the Corporation founded by Thomas Guy in the modern style. The shield should be of a correct shape for practical use and should not be too fanciful in design. The helmet should bear a correct relationship in size to the shield. The real mediæval helmet was almost as big as the shield. In Victorian heraldry it was always depicted much too small. In the grant to the Hospital a peer's helmet is shown—*i.e.*, silver, with gold grills or bars and gold-garnished. Guy's men will not quarrel with these heraldic honours. No other hospital has supporters and a peer's helmet. The crest is displayed on the helmet on a wreath of the bearer's colours, usually the first mentioned in the blazon or description of the shield,



in this case black and gold. The crest should be shown of suitable size in relation to the helmet. The crest is the figure of Charity, clothed in blue, succouring three children. A helmet above a shield without a crest has no meaning. It is lamentable that this mid-Victorian presentation of the Hospital arms should have been reproduced for so long and even carried out on the Memorial of the first World War.

The supporters should be in relationship to a shield of about 4 feet 6 inches in height. The lambrequin, or mantling, was a piece of material hanging from the helmet and covering the nape of the neck and shoulders of the wearer. It was probably introduced as a protection from the sun during the crusades, but it was found also to be a useful protection from sword cuts at the same time. It would be cut in action

and one who had been in several frays would be proud to show his mantling cut to ribbons. Consequently herald painters always show the mantling flowing in artistic streamers.

The shield is divided into partitions ; in the case of the Guy's shield by a chevron. The designs superimposed are known as charges. The chevron should be boldly drawn and in no sense skimpy. The charges should fill the spaces of the shield ; in a great deal of mid-Victorian heraldry the charges were small and poorly drawn.

I would suggest that the Clubs' Union uses a shield of more pleasing shape on blazers and shirts and that the helmet be omitted from now on. The colours on the shield must never infringe the correct heraldic description of them.

Hospital Information, etc.

Pass List

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
F.R.C.S.
May, 1946.

L. O. Knox — H. F. Lunn
T. L. T. Lewis — P. F. Milling

UNIVERSITY OF CAMBRIDGE.
FINAL M.B. EXAMINATION.
Easter Term, 1946.
PART I.—Surgery, Midwifery and Gynæcology.

A. P. Baker — J. L. Moffatt
G. T. F. Braddock — J. M. Palmer
J. Crossley

PART II.—Principles of Physic, Pathology and Pharmacology.

J. A. Bulleid — H. W. Trusted
La Hass — W. van't Hoff
K. E. Jefferson

Anatomy.
W. S. Sugden.

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
June, 1946.

Surgery.—R. N. H. Vann.
Pathology, Bacteriology and Forensic Medicine.—W. F. Belsham, J. O. Kelsey.

CONJOINT BOARD.
June, 1946.
Chemistry.

M. F. Ashby — S. Morgan
W. A. B. Brown — A. B. Price
D. W. Campbell — W. J. A. Reed
H. E. H. Gillett — P. J. Saville
A. E. Jacques — W. H. Watson
H. I. Levene

Physics

A. G. Hitchcock — J. L. Wynne
H. I. Levene

Elementary Biology.

D. W. Campbell — R. L. G. Thornton
G. Dixon — W. H. Watson
H. I. Levene — D. R. Whittington
W. J. A. Reed

Anatomy and Physiology.

L. C. Bellsham-Revell — D. J. Joubert
C. R. Lynn
I. B. Davies — G. F. M. Pierce
G. A. L. G. Glazebrook — L. Tann
W. N. Whamond

Anatomy.
D. H. Le Clus

Pharmacology and Materia Medica.

G. F. Barnes — S. J. Harris
J. Candy — J. A. R. Parker
H. M. C. O'Driscoll

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
L.D.S.
FIRST AND SECOND PROFESSIONAL EXAMINATION.
May, 1946.
Dental Metallurgy.

C. B. Bowes — H. A. H. Ohlrich
K. E. Clokey — L. Roth
J. D. Derry — H. L. Scott
W. F. Dobson — W. R. Thomas
R. G. Fricker — H. G. S. Thomson
J. D. Haworth — B. R. Venning
M. J. Humphry — T. K. Walker
A. A. Leigh — G. J. L. Want
A. P. Leech — N. J. Wood
G. E. Moore — S. L. Woolgar
O. D. Mazroo

Dental Mechanics.

E. J. Annen — G. G. Phillips
P. J. Attenborough — W. G. Selley
A. A. Bailey — R. E. Simmons
E. B. Busfield — K. S. Sunaway
D. J. W. Foster — R. D. F. Thiel
T. R. Foster — G. P. J. Williams
B. M. Gray — W. J. Wolfsohn
G. Holding — P. J. F. Woodroof
M. B. Lacey

Anatomy and Physiology.

R. D. Baker — B. A. Hill
L. Becker — D. J. Murch
W. Finkel — R. E. B. Turner

Special Anatomy and Physiology.

P. J. Attenborough — G. G. Phillips
A. A. Bailey — D. Rabinovitz
E. B. Busfield — A. P. Rowland
B. Engelsman — W. G. Selley
T. R. Foster — R. E. Simmons
M. W. Harber — K. S. Sunaway
D. G. D. Harris — R. D. F. Thiel
A. W. Hilliam — K. D. Watts
G. Holding — C. R. Wilkinson
D. W. Leatherbarrow — G. P. J. Williams
R. S. Wilson
J. W. McLean — P. J. F. Woodroof

FINAL EXAMINATION.
June, 1946.
PART I.—Surgery.

D. W. Farren — R. A. Morsman
M. C. Grant — A. Rooms
H. M. Hughes — R. A. J. Shaw
E. T. Hunt — M. J. L. Sykes
D. G. Jones — S. B. Taylor
S. F. Lamb — C. W. H. Williams

PART II.—Dental Surgery.

B. M. Bilton — G. J. Marks
J. F. Bowes — A. K. Parsonage
D. W. Farren — J. S. Rose
R. Freeman — J. D. Rumble
H. C. Goudge — K. Salomon
M. C. Grant — P. G. Shingler
W. D. Hannaford — E. M. Sycamore
J. G. L. Knowles — I. B. Walters
W. O. King — A. J. L. Wheatley
S. F. Lamb

The Services

AWARDS.

In recognition of gallant and distinguished services while prisoners of war.

M.B.E. (Military).

Major (Temp.) H. M. S. G. Beadnell, R.A.M.C.
Captain T. S. Protheroe, R.A.M.C.

Mentioned in Despatches.

For gallant services in the Mediterranean
Miss D. James.

Change of Address

P. D. Bryant, F/O. R.A.F. (190691), R.A.F. Hospital, Singapore.
N. F. Clarke, M.B.E., M.R.C.S., L.D.S., 140, Harley Street, W.1. (Tel.: Welbeck 2720.)
A. H. B. Kirkman, F.R.C.S., "Langdale." Seaton, Devon. (Retired).
M. MacKenzie, M.D., 86, Harley Street, W.1. (Tel.: Welbeck 8682.)
J. W. Shackle, M.B., Ch.B., 53, Green Street, W.1, and 5, Bracknell Gardens, N.W.3. (Tel.: Mayfair 6080.)
R. Vaughan Payne, S/Ldr. R.A.F. (202838), No. 10, R.A.F. General Hospital, Karachi, India.

Appointment

G. Morvent A. Brown, L.D.S., has been appointed Hon. Dental Surgeon to the Royal Infirmary, Cardiff.

Papers by Guy's Men

Graham, A. J. P. A case of bilateral pneumo-thorax and bilateral penetrating wounds of the diaphragm with recovery. *Ibid.*, 394.

Saner, F. D. A case of carcinoma coli in a child. *Ibid.*, 398.

Warner, R. G. H. The Teviot Report—Dental mechanics. *Brit. Dent. J.*, 1946, **80**, 301.

Smyth, J. F. N. The design of units. *Ibid.*, 303.

Hart, M. C. Experiences of a Field Dental Laboratory in the B.L.A. *Ibid.*, 305.

Lane-Roberts, Cedric. Infertility in Women. *J. Obst. & Gynæc. Brit. Emp.*, 1946, 53, 148.

Townrow, V., and Another. Fatal actinomyces infection of the middle ear. *J. Laryngol. Otol.*, 1945, **60**, 329.

Blacker, C. P. Positive Eugenics: a proposal. *Eugenics Review*, 1946, **38**, 25.

Jacoby, N. M. Pyloric stenosis: selective medical and surgical treatment. *Brit. Med. J.*, 1946, i, 721.

Saner, F. D. Acute appendicitis. *Med. World*, 1946, **64**, 391.

Eckhoff, N. L. Cancer of the Rectum. *Clin. J.*, 1946, 75, 92.

Rix, R. E. Deglutition and the Teeth. *Dental Rec.*, 1946, **66**, 103.

Vertue, H. St. H., and Gration, Hilda. Acute nephritis. *Nursing Mirror*, 1946, **83**, 65.

Clarke, C. Astley, and Another. Nutritional neurotherapy in prisoners-of-war and internees from Hong Kong. *Lancet*, 1946, i, 734.

Williams, P. H. Trilene auto analgesia in dentistry. *Brit. Dent. J.*, 1946, **80**, 330.

Barber, H. W. Dermatoses of the menopause. *Practitioner*, 1946, **156**, 333.

McArdle, M. J., and Another. Convalescence after head injuries. Advice for the patient's relations. *Ibid.*, 370.

Nelson-Jones, A. Ménières disease. *Ibid.*, 384.

Lane-Roberts, C. Sterility. *Ibid.*, 393.

Taylor, A. Gordon. The Teviot Report. *Pub. Health*, 1945–6, 59, 15.

Macintosh, R. R., and Another. Clinical trials of Kemithal. *Lancet*, 1946, i, 767.

Ogilvie, Sir Heneage. A note. *Brit. Med. J.*, 1946, i, 800.

Vertue, H. St. H., and Gration, Hilda. Osteogenesis imperfecta. *Nursing Mirror*, 1946, **83**, 137.

Reading, Philip. Cortical Mastoidectomy. Use of penicillin in plasma clot. *Lancet*, 1946, i, 811.

Allen, Clifford. An evaluation of physical methods of treatment in mental disease. *Med. Press*, 1946, **215**, 376.

Shaw, Maurice. Diverticulitis and diverticulosis. *Practitioner*, 1946, **156**, 411.

Bishop, P. M. F. The Female sex hormones. *Ibid.*, 465.

Shay, H. B. An appliance for the expansion of the eye-socket. *Brit. Dent. J.*, 1946, **80**, 368.

Vertue, H. St. J., and Gration, Hilda. Pernicious Anæmia. *Nursing Mirror*, 1946, **83**, 165.

Macintosh, R. R., and Another. Pulmonary exchange during artificial respiration. *Brit. Med. J.*, 1946, i, 908.

Knott, F. A., and Southwell, Neville. Aerosol penicillin in the oxygen tent. *Arch. Dis. Childh.*, 1946, **21**, 16.

Law, Frank. Ocular sequælae of head injuries. *Nursing Mirror*, 1946, **83**, 163.

Dowling, G. B., and Another. Treatment of Lupus Vulgaris with calciferol. *Lancet*, 1946, i, 919.

Brockington, C. F. Homelessness in children: causes and prevention; Analysis of unparented children in three English counties. *Ibid.*, 933.

Rushton, Martin A. Unilateral hyperplasia of the mandibular condyle. *Proc. Roy. Soc. Med.*, 1945–6, 39, 431.

Mukerji, H. C. Tuberculosis of service men: a preliminary report. *Brit. Med. J.*, 1946, i, 987.

Marriages

HUNTLEY—GRIFFITHS.—On July 6th, 1946, at the Parish Church, Epsom, Martin Huntley, M.R.C.S., L.R.C.P., to Phyllis M. Griffiths, S.R.N.

ROBERTS—GOODMAN.—On June 29th, 1946, at St. Mary's Church, Osteley, C. Glynn Roberts, F/O. R.A.F., to Margaret D. Goodman.

EASTES—LEE.—On July 6th, 1946, at Stutton Church, Suffolk, C. N. Eastes, Capt., R.A.M.C., to Marjorie M. Lee, S.R.N.

Births

SECHIARI.—On July 11th, 1946, to Mary (*nee* Williams), wife of Dr. G. P. A. Sechiari, of 220, London Road, Twickenham—a brother for Peter.

STEWARD.—On July 6th, 1946, at Nuffield House, to Margaret (*nee* Reading), wife of Dr. Graham Steward, of "Hazeldene," Chipstead, Surrey—a daughter.

Deaths

BENNETT.—On July 10th, 1946, suddenly, at 39, Hill Street, Mayfair, Thomas Izod Bennett, M.D., F.R.C.P.

CROFTS.—On July 7th, 1946, after a short illness, Dr. A. Douglas Crofts, of Old Institute House, Windsor.

GOSSE.—On July 13th, 1945, at Wincote, Westfield Lane, St. Leonards-on-Sea, Hope Wilkes Gosse, M.R.C.S., L.R.C.P., M.B.E., aged 99, formerly Eccleshall, Staffs.

EDS. {R.H.N.L. J.E.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

WHEN we first came to Guy's we noticed, as a strange coincidence, that the street in which our hospital stood bore the same name as one of the other teaching hospitals, to which we had nearly gone instead. Soon, however, we learnt that this was no coincidence, but a relic of the past connection between the two hospitals. Later, we read of Keats and his student days at Guy's, and realised how close was the connection which then existed between the two medical schools. We learned, too, of the gateway through which Keats must have passed on his way from one hospital to the other; and of the significance of the old houses in St. Thomas' Street, now occupied by the Southern Railway offices. We looked at these few remaining buildings, glibly thought how small our rival must have been, and idly wondered by how many years it pre-existed us.

Now Mr. Brock, with his customary precision and passion for detail, has brought us sharply to our senses. In the illuminating article which we publish in this issue, he shows us that St. Thomas' pre-existed us not by a few years, but by many centuries; that its foundation rivals in age that of St. Bartholomews; and that the few buildings that we know are but echoes of a former glory.

We are already indebted to Mr. Brock for the clarity of his teaching; now the debt is doubled by this lucid exposition of our earlier environment, and the explanation of the name of the street in which we stand.

EARLY this year the college was reopened, and the housemen forsook the outpost of Doyle's, glad to descend the breakneck fire escape for the last time. We looked forward to the change for many reasons, not the least being the prospect of breakfast served at a later hour, to compensate for a night disturbed by the recalcitrant drip; or possibly, on very rare occasions, for the evening spent elsewhere. Living, as we then were, beside a small factory which specialised in shattering the dawn with the raucous noise of grinding machinery, we had often regretted in no uncertain manner our early wakening. So, in spite of the somewhat austere and uninviting aspect of the college, we packed our bags with few regrets.

But our dreams were soon shattered, and we awoke one morning to the sound of broken glass falling to the ground, mingled with the none too distant song of the British workman revelling in his task. We thought first that the whole college had fallen, then that the new Guy's was being built as we slept. But the workmen had come, not to build the new college, but to repair the old, renewing the glass roof over the old gym, and starting the long task of restoring the shattered fourth wall. The glass-breaking is now fortunately over, and peace reigns again in the morning; but the college is still alive with workmen, and we await with interest the results of their labours, and with keen anticipation the return of the lost amenities of life in the college.

MR. K. S. MACLEAN, to whom we extend our best wishes, is succeeded as President of the Residents by Mr. J. K. Martin. Mr. C. L. Joiner was elected Vice-President.

THE whole Hospital will wish to join us in congratulating the XI. on winning the Inter-Hospital Cricket Cup. An account of the final, which must have been, towards the end, an unusually exciting match, will be found on the Sports' page.

"Headache"

A Clinical Lecture delivered at Guy's Hospital by

SIR CHARLES SYMONDS, K.B.E., F.R.C.P.

GENTLEMEN,—Headache is a common symptom but it is only in the last few years that we have had any clear idea of its mechanisms. There have been three main sources of information.

First there has been the opportunity during operations on the head under local anæsthesia of observing which structures are sensitive to pain. From such observations it has been shown that all the tissues covering the cranium are pain sensitive and especially the arteries. The cranium itself is insensitive—that is to say, that after the periosteum has been stripped the skull can be drilled or sawn through without the patient being aware of any sensation except the noise. Of the intracranial structures most of the dura matter, all the pia-arachnoid and the brain substance are insensitive. The parts of the dura which are sensitive are those which cover the base of the skull, and the tentorium. Pressure upon the latter structure causes pain which is referred to the brow on the same side of the head. The falx, on the other hand, appears to be insensitive to pressure. Although the dura itself is insensitive except at the base, the larger dural arteries are everywhere sensitive; for example, crushing the middle meningeal artery causes pain. Traction upon the walls of the large venous sinuses and their main tributaries also causes pain and so does traction upon the large arteries at the base of the brain. Stimulation of the sensory nerves intracranially, the fifth, ninth, tenth and second cervical, causes pain of appropriate distribution.

It is to be noted that with the exception of the arteries and the sensory nerve trunks, all the pain sensitive intracranial structures play an important part in anchoring the brain to the cranium.

The second source of information is from the experimental production of headache. The intravenous injection of 0.1 mg. of histamine causes in most subjects a headache having the following characters. It begins one minute after the injection, reaches its maximum intensity half a minute later and gradually passes off in about ten minutes. It is of a throbbing nature and of generalised distribution. The effect of this injection of histamine upon the general circulation is as follows:—Within twenty seconds there is flushing of the face with a fall of blood-pressure. The fall of blood-pressure lasts for less than a minute, so that the headache begins when the blood-pressure is returning to normal and reaches its maximum intensity later. It is known that histamine also

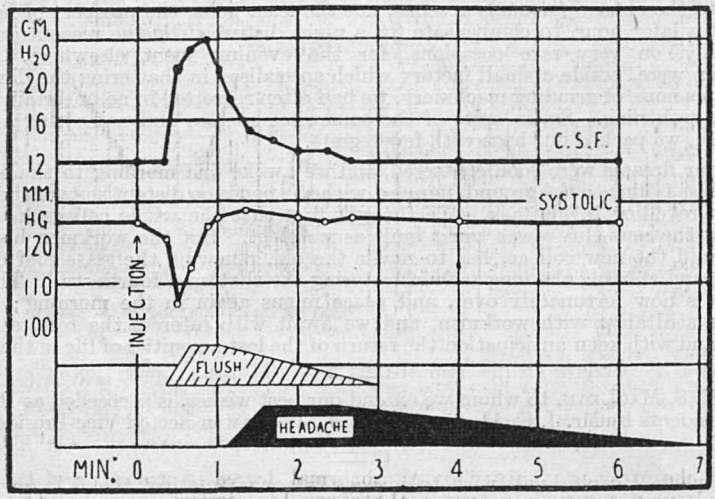

FIG. 1.—Showing the C.S.F. pressure, the systolic B.P., the facial flush and the headache before and after an intravenous injection of 0.1 mg. histamine at 0 min.

causes dilatation of the arteries of the meninges and on the surface of the brain. This in turn leads to an increased volume of the intracranial contents and a rise in the cerebrospinal fluid pressure. It is not, however, until the C.S.F. pressure has almost returned to its normal level that the headache begins. The headache, therefore, cannot be due to increased intracranial pressure. This is further shown by the fact that histamine headache can be relieved by raising the C.S.F. pressure either by compressing the jugular veins, or by the intracranial injection of normal saline. Histamine headache can also be temporarily relieved by a second injection of histamine or by the inhalation of amyl nitrite, the relief being coincident with the fall of blood-pressure caused by these drugs.

Thus it appears that histamine headache is relieved by increasing the pressure outside the walls of the intracranial arteries or by diminishing the pressure within them. This suggests that the headache is due to stretching of the arterial walls and a further clue to the sequence of events after histamine injection is provided by the observation in animals that the dilatation of the cerebral arteries continues for a short time after the arterial pressure has begun to return, so that the walls of these vessels not yet having regained their tone may be abnormally stretched by a normal internal pressure.

I have described these observations and conclusions in some detail because they have been the basis of much other work. They were made originally by Pickering in this country and confirmed by Wolff and others in America.

It has been shown that the headache of experimentally induced fever can, like histamine headache, be temporarily relieved by artificially raising the C.S.F. pressure; and by an ingenious method of recording the pulsations in the C.S.F. manometer, which reflects the pulsation of the intracranial and intraspinal arteries, it has been demonstrated that the onset of febrile headache is associated with an increased amplitude of pulsation, and that fluctuations in the intensity of the headache are associated with corresponding fluctuations of amplitude. It would appear, then, that

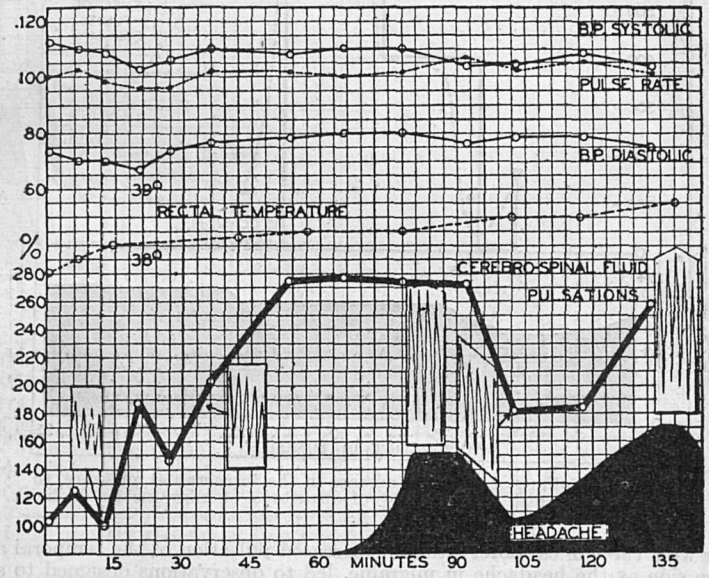

FIG. 2.—Relation of the headache associated with intravenous injection of typhoid vaccine to the amplitude of pulsations of the C.S.F. The onset of headache was associated with an increased amplitude of pulsations, and a spontaneous remission in the severity of the headache with a corresponding decrease in amplitude of pulsations.

the headache of fever is caused by an abnormal degree of stretching of the arterial walls, and since raising the intracranial pressure by injection of saline into the theca will relieve the headache, we may conclude that the arteries chiefly concerned are those within the skull.

Another experimental headache is that which may be produced by the withdrawal of 20 c.c. of C.S.F. by lumbar puncture. With this kind of headache we are familiar as an occasional sequel of diagnostic lumbar puncture when it is due to excessive leakage of C.S.F. This headache is remarkable for its constant relation to posture. It is relieved by the horizontal and aggravated by the erect positions. It must be due to a diminution of cerebrospinal fluid for the liability to headache in the erect posture can be very much reduced by making good the deficit with normal saline. It is, however, temporarily increased by jugular compression which raises the intracranial pressure, so that it is incorrect to regard lumbar puncture headache as "low pressure" headache. It is probably due to traction upon the pain sensitive structures anchoring the brain to the skull which are stretched in certain postures owing to the depletion of C.S.F. which normally provides a water-bed for the brain. The great venous sinuses and their tributaries and the tentorium might be especially liable to be affected in the erect posture.

Our third source of information about the mechanism of headache is observation in disease. In migraine the headache is of a throbbing character, resembling in this respect that induced by histamine or fever, and it might reasonably be expected to have the same basis, an abnormal degree of stretching of the intracranial arteries. But the headache of migraine is not relieved by raising the C.S.F. pressure. This,

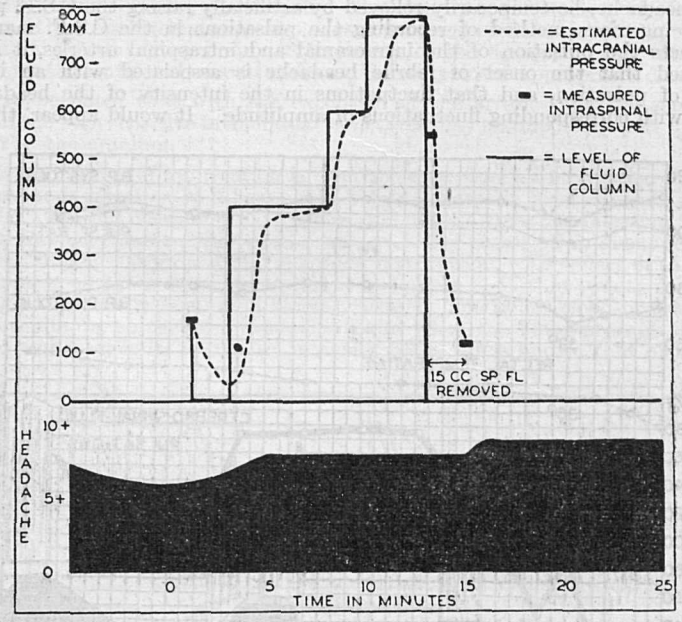

FIG. 3.—Failure of induced increase in the intracranial pressure to diminish the intensity of an attack of migraine headache.

together with the clinical observation of increased pulsation of the temporal artery on the same side as the headache in migraine, led to observations designed to show the relation of the amplitude of pulsation in this artery to the intensity of headache. The device for recording temporal pulsation also afforded an opportunity for observing the relation between this and the effect of ergotatmine tartrate which was already known to relieve migraine headache. The result was striking. There was a constant parallelism between the amplitude of pulsation in the temporal artery and the intensity of headache on that side, and the intravenous injection of ergotatmine tartrate simultaneously effected—(1) a rise of systemic blood-pressure due to general vasoconstriction; (2) a decrease of amplitude in the pulsations of the temporal artery due to local vasoconstriction; (3) diminution and eventually relief of headache.

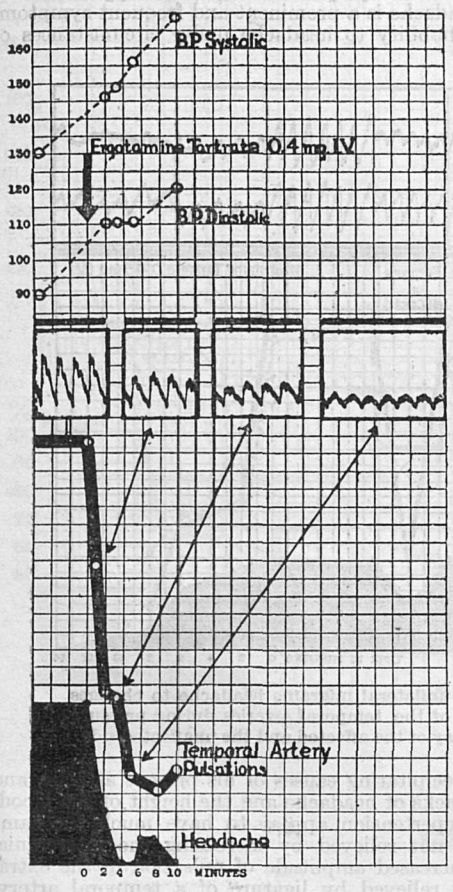

FIG. 4.—Relation of the amplitude of pulsations of the temporal artery to the intensity of migraine headache after administration of ergotatmine tartrate. Representative sections of the photographic record are inserted.

It may be concluded that the pain of migraine is caused by the dilatation and distension of cranial arterial walls and that the therapeutic effect of ergotatmine tartrate depends on its ability to produce prolonged and powerful vasoconstriction.

That the headache of migraine is related to the stretching of extracranial arteries has also been shown in other ways. Pressure on the common carotid artery during an attack of migraine reduces the severity on that side and at the same time reduces in rough proportion the amplitude of pulsation in the temporal artery. When the headache is strictly unilateral, as it often is, carotid compression on the side of the headache greatly relieves it (see Fig. 5).

Ligature of the temporal artery in certain cases of migraine has given freedom from pain in this area in subsequent attacks. Thus it seems certain that stretching of the extra-cranial arteries is the most important source of pain in migraine, but this does not exclude stretching of the intracranial arteries as a contributory cause. In fact, there is positive evidence for this, for we know that the classical visual aura of migraine is due to disturbance of cortical function, and must therefore have an intracranial cause and, in a few cases of migraine with severe deep-seated temporal pain, ligature of the middle meningeal artery is reported to have given relief. The mechanism of migraine headache described offers an explanation of the not very uncommon occurrence in some attacks of pains in face or neck, which may be attributed to distension of the arteries in these regions.

Headache is a common but inconstant symptom of arterial hypertension.* Clinical observation shows that when headache is a prominent and frequent symptom, the patient has usually had a lifelong liability to headache under circumstances of

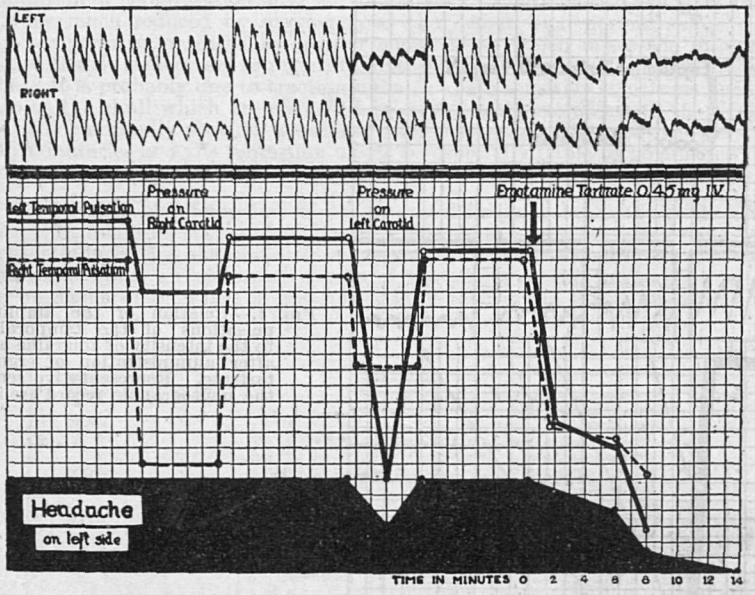

FIG. 5.—Relation of intensity of a unilateral migraine headache to changes in amplitude of pulsations of the temporal arteries during pressure on the common carotid artery of the affected and the unaffected side.

fatigue and stress, that these are the precipitating causes of his present attacks, and that there is no relation between the attacks of headache and the height of the blood-pressure. The headaches of arterial hypertension appear to have much the same basis as those of migraine. They are not relieved by increasing the intercranial pressure, they are associated with an increased amplitude of pulsation in the extra-cranial arteries and they can be locally relieved by ligature of a temporal artery. Furthermore, an attack of headache can generally be relieved by an injection of ergotatmine tartrate. This last observation is of especial interest for the injection causes a rise of blood-pressure. Here is additional proof that a raised blood-pressure alone does not cause headache (see Fig. 6). The explanation offered for hypertensive headaches is that variations in the tone of the walls of the cranial arteries are common, and commoner in some persons than in others. If the blood-pressure is high, a relaxed artery will be mores tretched, and so the liability to headache will be increased and the pain will be greater.

The headache of intracranial tumour was for a long time supposed to be due to stretching of the parietal dura from increased intracranial pressure, but this explanation no longer stands. Severe headache may be present in cases of cerebral tumour when the intracranial pressure measured by a manometer is normal. Headache may sometimes be provoked by a sudden diminution of the space occupying lesion as when a cyst is tapped. Experimentally it has been shown that in a normal man the intracranial pressure can be raised by the lumbar injection of normal saline to over 500 m.m. and maintained at this level for ten minutes without causing headache. An observa-

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* I exclude consideration of the relatively rare condition known as hypertensive encephalopathy in which headache is severe and is associated with a raised C.S.F. pressure.

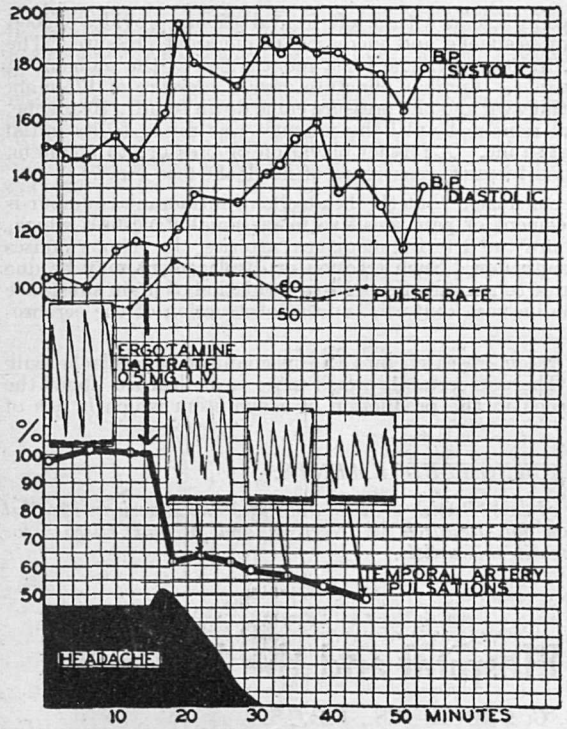


FIG. 6.—Effect of ergotamine tartrate on headache associated with arteria hypertension. The decrease in the intensity of headache was associated with a decrease in amplitude of pulsations of the tempora artery.

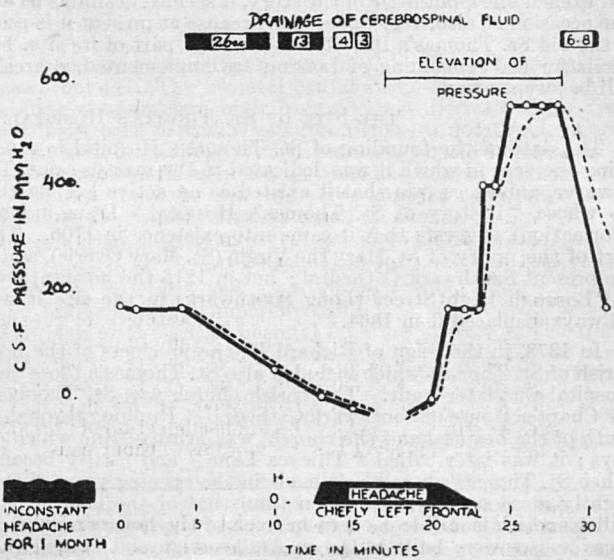


FIG. 7.

Induction of headache by drainage of C.S.F. and failure of induced elevation of intracranial pressure to 550 mm. to cause headache in a patient with a left parietal glioma.

tion by Wolff and his colleagues in a man with a left frontal glioma provides a good example of the independence of headache and increased intracranial pressure. The patient had had intermittent bifrontal headache for a month, but at the moment of observation was free from headache. Lumbar puncture gave a pressure of 175 m.m. Thirty-nine c.c. of fluid were withdrawn and the pressure came down to nil. Headache, chiefly left frontal, resulted and remained until the pressure was raised to its initial level by the injection of normal saline. A further elevation of pressure to 550 m.m. maintained for five minutes failed to cause recurrence of headache (see Fig. 7).

We are led therefore to the conclusion that the headache of intracranial tumour is due to traction upon or displacement of pain-sensitive intracranial structures which, as we have seen, include basal dura and arteries, meningeal arteries, the venous sinuses and their tributaries and the tentorium. Such traction or displacement may be due to the local effect of the tumour or to remote effects from herniation of brain substance beneath the falx or through the incisura tentorii, or from obstruction of the cerebro-spinal fluid circulation.

This incomplete account of recent research into the mechanism of headache will, I hope, excite your curiosity. There is certainly much more to be learned about the structures and functions concerned in the production of a symptom which is one of the commonest kinds of pain.

ACKNOWLEDGEMENTS.

We are indebted to the Editor of the "British Medical Journal," the American Medical Association, and the Association for Research in Nervous and Mental Disease for permission to reproduce the figures in this article.

St. Thomas's Hospital and the Borough

By R. C. BROCK, M.S., F.R.C.S.

TO most people the mention of St. Thomas's Hospital means the present buildings on the Albert Embankment. Only few are aware of the long history of St. Thomas's Hospital in the Borough and as I am sure many present Guy's men and women know but little of the story, it seemed desirable to write something about it. The occasion is, also, very opportune because at present it is possible to study a portion of the old St. Thomas's Hospital and a large part of its site, but if certain of the proposals for the replanning of London are implemented, a great deal of what remains will be swept away.

The Site of St. Thomas's Hospital.

The date of the founding of St. Thomas's Hospital is usually given as 1173, this being the year in which it was dedicated to the martyr saint, Thomas à Becket. It is, however, almost certain that it existed as an active hospital before this, and Parsons (to whose "History of St. Thomas's Hospital" I am indebted for much valuable information), suggests that it came into existence in 1106. The original building was part of the priory of St. Mary the Virgin (St. Mary Overie), and was on the north side of the present Southwark Cathedral; but in 1215 the hospital found new quarters across the Borough High Street (Long Southwark) in the site it was to occupy until the railways displaced it in 1864.

In 1378, in the reign of Richard II, the precincts of the hospital became the small parish of St. Thomas which included also St. Thomas's Close on the site of which Guy's Hospital was later built. The parish church was St. Thomas's church which is now the Chapter House of Southwark Cathedral. Running through the parish, immediately south of the hospital and the church, was Trinity Lane which dates back to very early days; it was later called "Thieves Lane" and finally became St. Thomas's Street. When St. Thomas's Street was made in the opening years of the 18th century it took a slightly more southerly direction than that of the lane, leaving a space enclosed by railings which is still to be seen in front of the houses on the north side of the street; these houses were built in Queen Anne's reign and housed the various officers of the hospital. This boundary of the hospital was broken by a side entrance which is said to have been there since the time of King John. It will be more fully described later.

Right up to the first part of the nineteenth century the main entrance to the hospital was in Long Southwark (now the Borough High Street), but was small. The hospital itself, up to this time, occupied a rather narrow strip north of and parallel to St. Thomas's Street. In 1832 old London Bridge was pulled down after the present bridge had been built slightly more to the west; this involved a change in direction of that part of the Borough High Street between St. Thomas's Street and the bridge. All the houses and shops facing the High Street and between the hospital and Tooley Street were pulled down and the Governors of St. Thomas's Hospital then took the opportunity to build two large ward blocks (north and south wings, Fig. 1) flanking

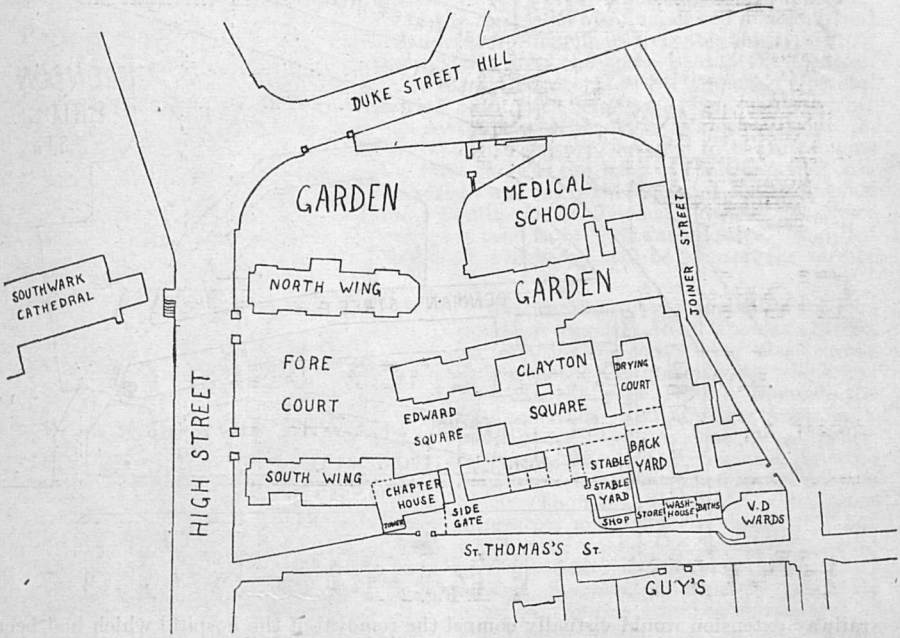


Fig. 1

a large fore-court which opened by two entrance gates into the High Street and gave the hospital an impressive frontage. The hospital boundaries now extended right up to Duke Street Hill, the new thoroughfare built from the new Borough High Street (which incidentally was to have been named Wellington Street) to join Tooley Street. Figure 1 shows the boundaries and buildings of the hospital after this expansion. It should be realised that after crossing London Bridge from the north, from this time until 1864, one would have seen the large and inpressive hospital buildings standing in spacious grounds and facing the cathedral across the High Street.

The plan in Figure 1 is based on a tracing I have made from a drawing in my possession which actually came from Rennie's office (Rennie built the new London Bridge) and shows the streets, buildings and approach to the old bridge with the suggested new streets and bridge approach superimposed; it is, therefore, I presume, reasonably accurate. The plan of the actual hospital building was completed from a plan in Professor Parsons' book. The curved building line in the north-west corner should be noted for it is retained to-day in the sweep of Findlater's corner (Fig. 2). This north-west corner of the hospital was occupied by a garden enclosed by railings. I have engravings of two drawings made in about 1840, both of which show two white stone pillars joined by a railing in this corner. These will be mentioned again later.

The passing of St. Thomas's Hospital from the Borough.

In 1833 the London and Greenwich Railway built its terminus on part of the hospital's property and thus the present London Bridge station began. In 1835 it was joined by the London and Croydon Railway, which later became part of the London Brighton and South Coast Railway. In January, 1859, however, St. Thomas's Hospital

learnt the much more serious news that the South Eastern Railway Company intended to appeal to Parliament for powers to extend its line from London Bridge Station across the river to Hungerford Market (now Charing Cross Station), and this line was to cross the north-western corner of the hospital's garden within a few feet of the north wing. The project was opposed and the railway company offered £10,000 in compensation, but it soon became clear that Parliamentary permission would be granted and the

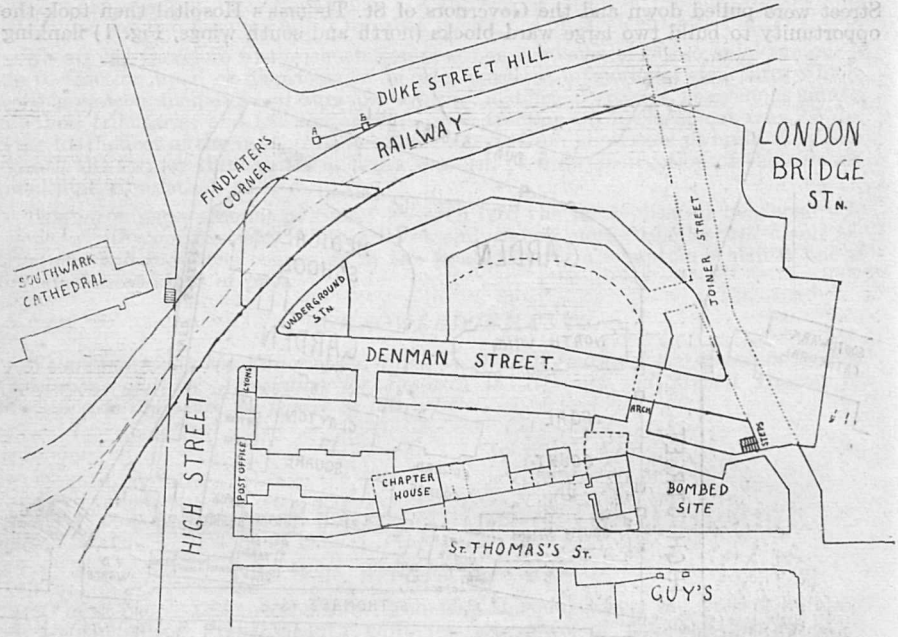


Fig. 2

railway extension would virtually compel the removal of the hospital which had been in the Borough for 550 years before Guy's. The removal, however, offered a practical solution to the "almost impossible situation which Thomas Guy had brought about when he unwittingly placed a rival hospital beside St. Thomas's, thinking the one would supplement the other." The quarrels of the "United Hospitals" had culminated in their complete separation in 1825 when the Guy's Medical School was founded as a separate entity. The governors told the railway company that no amount of compensation would atone for the damage proposed to be done to the hospital, and that if the extension were to be built the company must buy the whole of the hospital ground and buildings. The purchase price was eventually assessed at £296,000 and St. Thomas's Hospital moved from the Borough in 1864, thus ending an association of nearly seven centuries.

The Fate of Old St. Thomas's Hospital.

The development of the old hospital site has swept away almost all of the original buildings, but not quite all. In Figure 2 I have tried to show the present lay-out on the same scale as that in Figure 1. I have tried to make it as accurate as possible and I think there are no more than minor disproportions; the general plan is essentially correct. A glance shows that the original "block" occupied by the hospital remains, although intersected by new roads. Moreover, in addition to some of the original buildings, a few other features can be identified.

If we start at the north-western corner the rounded curve of Findlater's corner should be noted and compared with the original building line; the curve has been interrupted by one of the roads leading to London Bridge Station but it is still there. Separating this road from Duke Street is a barrier or partition formed essentially by two square white stone pillars, marked A and B in Figure 2, and joined by iron railings which are partly hidden by advertisement hoarding. These appear to be the same two stone pillars that marked the boundary of St. Thomas's Hospital Garden, and if

one looks at them in association with their surroundings they are quite inexplicable unless their earlier origin is known. The big block formed by the north wing has been swept away but the south wing remains and the present Borough Post Office is built on to its front facing the High Street. Several good views can be obtained of this building: one is from St. Thomas's Street where it can be seen rising high above the Imperial restaurant and adjacent shops just west of the Chapter House. A moment's thought will show that no one would have built such a handsome white stone-faced building if it had been designed to dwell in such obscurity. It can be seen rising above the post office if one stands on the opposite side of the High Street, but a better view is obtained from the corner of Southwark Street. The most impressive view is obtained, however, by going a few yards up Denman Street; a little higher up than the underground station and on the opposite side of the road is an opening, closed at nights and week-ends by a sliding iron gate, but open during working hours to enable the inquisitive to trespass. If one walks through this opening into the space behind the Denman Street buildings one is standing in part of the old Forecourt of St. Thomas's Hospital and the great white mass of the south wing block rises before one; truly an inspiring sight which compels one to think of the past glories of St. Thomas's in the Borough. This handsome block is, of course, of the nineteenth century, but next to it are remains of the old eighteenth century hospital. First there is the back of the Chapter House (the old parish church of St. Thomas's parish) and then the backs of the eighteenth century houses with whose façade we are familiar in St. Thomas's Street. A glance at Figure 1 will show that we are now in what used to be "Edward Square," so called because it contained the statue of Edward VI which can still be seen on the terrace of the Albert Embankment.

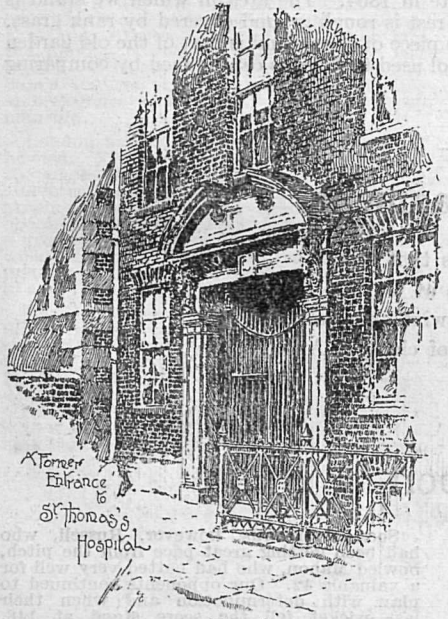


Fig. 3

To continue the inspection of the buildings we return to St Thomas's Street, again noting the south wing block as we approach the Chapter House, which was built in the year 1700. Beyond the Chapter House and standing back in a pleasant recess behind the railings, befitting their old-world atmosphere, are the houses which were occupied by the officials of St Thomas's Hospital. The most interesting and attractive is the first one which used to be the Treasurer's house and was built in the year 1704. The present magnificent doorway with its handsome Queen Anne hatchments, is of great historical interest because, as can be seen from Figure 3, the ground used to be interrupted by the side entrance into St. Thomas's Hospital, which has already been mentioned as dating back to the days of King John. It is still possible to look right through the hall of the present house into that part of Edward Square in which we stood when we entered from Denman Street, and where the old opening can still be seen. This is the entrance which was used by Guy's and St. Thomas's students in passing from one hospital to the other for lectures and demonstrations and to watch operations in the days when the two formed the "United Hospitals." Most of the lectures were given in the lecture theatre in St. Thomas's and not in Guy's. Even after the Guy's Hospital Medical School was founded in 1825, as a culmination of many bitter quarrels, the students of both hospitals still retained the right of seeing operations at both hospitals until an unfortunate incident in 1836. On this occasion an attempt was made to eject some Guy's men from the theatre when a particularly interesting operation was to be performed. A free fight followed, the police were called in and six students were arrested and ultimately tried at the Kingston Assizes, three of them being fined £10 and bound over for two years. The St. Thomas's governors then forbade Guy's students to attend operations at St. Thomas's and thus the last link between the two hospitals was broken. We should think of these far off days and the long and profitable

association between the two hospitals when we walk across St. Thomas's Street and see the doorway to the old Treasurer's House.

The other houses in the row were occupied respectively by the receiver or renter, the minister and the apothecary. At the end of the row was the Treasurer's stable and in front of it was the stable-yard. Although the yard has been half-built over it still remains and can easily be seen. Until 1818 some old houses immediately faced Guy's entrance but they were then replaced by a low range of buildings shown in Figure 1, of which only one remains to-day. It has a front curved at the western end and used to be a one-storey shop let to the surgical instrument maker, Laundy. Down Brothers, of course, used to stand on the site immediately next to this shop but the whole of this corner is now bare of buildings as a result of the fire of December, 1940. It should be noticed that the " Foul Wards " as they were called, or V.D. wards, used to form the extreme corner of the site causing a slight bottle-neck which must have been corrected after 1864 because the building line now is straight. Just round the corner, in Joiner Street, there used to be a third entrance to the Hospital which led into the " back-yard."

The bare site opposite Guy's, on part of which Down Brothers used to stand, enables us to explore more of the site of old St. Thomas's. If we walk straight across it we come to an archway leading under Denman Street into a half-moon shaped space lying between Denman Street and the back of the sweep of shops that faces London Bridge station and contains the A.B.C., Stanley's, the Creamery, etc. It should be noted that the Denman Street frontage is still covered by hoardings and has not been developed since the railway bought the site in 1864. The area in which we stand is partly taken up by a service road but the rest is rough ground covered by rank grass. It is strange to think that this unattractive piece of waste land is part of the old garden of St. Thomas's on which the medical school used to face, as can be seen by comparing the two plans.

A Fragment

What a pity it is that ties
Arent fashionable at Guy's;
So that now 'betwixt chin and vest
Is three by two of chest. ANON.

Sport

Cricket

INTER-HOSPITAL CRICKET CUP

Semi-Final

GUY'S *v.* WESTMINSTER HOSPITAL.

(Played at H.O.P. on Wednesday, July 3rd.)

Won by 4 wickets.

In a heatwave, at the hour of noon, Guy's took the field in the Semi-Final of the Hospitals Cup.

The attack was opened by O'Driscoll and Carton Kelly with the new ball, and both in their first overs were successful in beating the batsmen and hitting the stumps—2 for 3. Again, in O'Driscoll's fourth over, a third wicket was taken with the score at 18. Now Westminster strived hard to right their precarious position and by steady, if slow, batting brought the lunch-time score to 70.

Soon afterwards, however, Russell, who had been getting great pace from the pitch, bowled Mahon, who had batted very well for a valuable 42. Our opponents continued to play with determination and when their last wicket fell the score stood at 148. O'Driscoll took 4 for 31. The Guy's innings was opened by Harvard Davis and Munro, but soon the former was l.b.w. and Platt took his place. He gave an exhibition of forceful play supported by the ever-steady batting of his partner at the other end. At 73 Platt left for 29. Munro, supported by Williams, brought the score to over a hundred before the latter was caught behind the wicket.

Surprisingly enough, the mediocre bowling claimed another three Hospital wickets before the match was won—Trist once again showing his capabilities with the bat. Munro was undefeated for a characteristic 53.

Scores.—Guy's 149 for 6 (Munro 53 not out); Westminster 148 (O'Driscoll 4 for 31).

The Final.

GUY'S *v.* LONDON HOSPITAL.

(Played on the St. Mary's Hospital Ground at Teddington on Thursday and Friday, July 18th and 19th).

Won by 2 wickets

In the final of the Inter-Hospital Cricket Cup, Guy's beat the London Hospital by two wickets. This match must surely rank among the closest and most exciting finals in the whole series. Played over two days and two innings, the result was in doubt until the end. Seldom has that glorious uncertainty which is the wonder of cricket been so in evidence.

There was some shaking of heads in the pavilion when the London captain elected to field on a wicket which was a little wet, even for an English July. The heads were stilled when four batsmen had come and gone and 16 runs were all to show. But Platt was there and Platt was Guy's that afternoon. The London men, Chew, Lloyd and Shaddick, were bowling for glory and the Cup, but Platt treated them all with superb contempt and hit 79 out of 123 scored while he was at the wicket. One especially remembers a stroke off Shaddick which threatened the pavilion windows. Trist and Graham lent subsidiary aid, but it was the final stand which really gave Guy's a total to reckon with. Billingham and O'Driscoll scorned convention and the London bowlers to raise 62 for the last wicket. O'Driscoll hit fearlessly and Billingham's innings showed that confident ease and elegance which always mark his batsmanship.

London batted; Carton Kelly and Russell bowled. Five men were out for 7 runs and the whole side for 40. Immaculate bowling and merciless fielding took their toll. Nothing abashed, London tried again and their opening pair gathered 48 delightful runs in a greying light before Platt threw down the wicket from the length of the pitch. The first day ended with London needing 139 to avert an innings defeat.

The morning saw them supremely confident. Surely these were not the men so cheaply rated the day before! On and on they batted; on and off bowled Carton Kelly, Russell and the rest. Five wickets were down for 99, but Lloyd and Simpson dispelled half formed ideas of a quick victory with a stand of 125. Here was probably the best batting of the match. Lloyd's innings was an exemplary combination of restraint and aggression, and was only ended by a breathtaking piece of stumping by Platt off Russell. Guy's discomfiture was not yet over for Shaddick brought in a bat that was never lifted to the shoulder and seldom to the knee, and collected twenty or so runs in a very long time. But time was of no consequence. Finally, Graham lured the last batsman to his fall and Guy's were left with 97 to win.

Have 97 runs ever been so hardly won? Quick wickets brought the fieldsmen to their toes and the bowlers to their best. Half of Guy's were gone for 48 and the pendulum was swinging sickeningly for them, as it had swung for London on the first day. A particularly vivid impression remains of Shaddick following each of his deliveries down the wicket, as if to add terror by grimace and gesture; and of Simpson, flinging himself to and fro to save the unsaveable and catch the uncatchable. Wickets continued to fall and it was only through moments of impending disaster that Guy's came to win. Trist and Graham, Holmes and Harvard Davis, gathered the runs for victory, and, once again, O'Driscoll, batting at a perilous moment for his side, did not fail them. The winning stroke was made, most fittingly, by Carton Kelly, who had achieved so much by his tireless accuracy. His match figures are worthy of record—51–17–83–8. None the less, those of Russell—43·5–13–86–8.

The suspense of the closing stages was electric, and the glint of watery sunshine on the Cup as it stood on the scorers' table must have fallen agonisingly on the eyes of the captains, Hanworth and Graham. The changing fortunes of this match, which led London from disaster so nearly to victory, will live long in many memories.

The cup was presented, amid scenes of considerable enthusiasm, by Mr. J. H. Busteed, whose name appears on the trophy as a member of the victorious Guy's elevens of 1885 and 1886.

Scores.—Guy's Hospital, 229 (Platt 79, Billingham 46, O'Driscoll 46 n.o.) and 97 for 8 (Trist 24, Chew 3 for 24). London Hospital, 40 (Carton Kelly 5 for 18, Russell 5 for 15) and 285 (Lloyd 76, Simpson 45).

Team.—E. W. Graham, (Capt.), J. D. Williams, L. D. Carton Kelly, A. E. Trist, I. A. H. Munro, H. M. C. O'Driscoll, A. M. Platt, R. Harvard Davis, G. Billingham, P. S. Russell, P. Holmes.

Hospital Information, etc.

Notices

BRITISH DENTAL STUDENTS' ASSOCIATION.

ANNUAL GENERAL MEETING.

The 1946 Annual General Meeting was held at Sheffield University on Friday, 12th July, with Professor G. L. Roberts in the Chair.

Delegates from every dental school in Great Britain and Northern Ireland were welcomed by the Pro-Vice-Chancellor of the University, and were entertained extremely well by the University authorities.

During our stay we attended an address by Arthur H. Condry, Esq., General Secretary of the Incorporated Dental Society on "The National Health Bill and Dentistry"; a clinical lecture by Dr. J. Osborne of Birmingham; and various social events.

At the annual general meeting we were pleased to welcome Professor Talmage Read of Leeds as our new President. After the presidential address, the Secretary reported on the progress of affiliation with the three main dental associations; Regional Secretaries gave news of their respective areas' activities; and the proposal to refer the alteration of the constitution to an *ad hoc* committee was approved.

Student Officers for the year were elected, and a report on the efforts of the Association with respect to the National Health Bill was then adopted.

Full details of all matters discussed will be given at the next meeting of the Dental Society.

L. G. RICHARDS, I. A. NELSON,
Guy's B.D.S.A. Representatives.

GUY'S HOSPITAL DENTAL SCHOOL
(UNIVERSITY OF LONDON)

Applications are invited from registered practitioners for the post of Assistant to the Director of the Department of Dental Mechanics and Prosthetics. Attendance is on six sessions a week at a salary of £500 per annum, commencing 1st October, 1946. The appointment is for one year in the first instance. Application forms, duly completed, should be forwarded before 16th September to The Dean, Medical and Dental Schools, Guy's Hospital, London, S.E.1.

THE INNOMINATE CLUB.

The Post-War Reunion Dinner will be held at the Trocadero Restaurant at 7 p.m. on Friday, 18th October, 1946. Price of Dinner, excluding wines, 17/6 (in advance).

All desirous of attending, please communicate with the Hon. Secretary.

G. T. HANKEY,
19, Harley Street,
Tel.: Welbeck 7476. London, W.1.

The Wills Library is anxious to obtain the undermentioned periodicals to complete sets for binding and would be grateful to any Guy's man who may be able to supply any of the parts.

British Journal of Surgery, 1942, V. 30, parts 117, 118.

Journal of Experimental Medicine, 1941, V. 73, parts 2, 4, 6.

Practitioner, 1940, V. 145, part 4; 1944, V. 153, part 1.

Pass List

UNIVERSITY OF LONDON.

M.D. EXAMINATION.

July, 1946.

Branch I (Medicine).

P. Harvey — J. C. Houston
C. F. Hawkins — J. R. Trounce

Branch III (Psychological Medicine).

A. M. Edwards.

Branch V. (Hygiene).

G. H. Taylor.

M.S. EXAMINATION.

July, 1946.

Branch IV.

(Laryngology, Otology and Rhinology).

J. B. Musgrove.

UNIVERSITY OF LONDON.

DIPLOMA IN MEDICAL RADIOLOGY.

June and July, 1946.

I. L. McKelvie

UNIVERSITY OF OXFORD.

Trinity Term, 1946.

Pharmacology and Principles of Therapeutics.

A. G. Parks.

General Pathology and Bacteriology.

A. G. Parks.

Medicine, Surgery and Midwifery.

H. L. Backhouse — G. A. K. Missen
T. A. Madden

CONJOINT BOARD.

Pathology.

July, 1946.

G. F. Barnes — W. E. MacLean
*S. Balfour-Lynn — *J. B. Moore
L. J. Evered — P. Read
E. J. F. Filose — C. J. Roux
S. J. Harris — J. Southgate
A. L. Jeanes

Medicine.

I. A. Blackmore — *J. B. Moore
*B. D. Grant

Surgery.

A. G. Atkinson — J. L. Jenman
J. B. Eades — J. Lederer
R. L. Edwards — A. A. Waterman

Midwifery.

G. D. Banyard — R. L. Edwards
L. W. Bowen — H. Herbert
J. B. Eades

Appointment

Order of St. John of Jerusalem.

Capt. R. S. Harper, M.R.C.S., has been appointed an officer of the Order of St. John of Jerusalem.

Papers by Guy's Men

Law, Frank. Glaucoma. *Clin. J.*, 1946, **75**, 129.

Robin, Ian G. Treatment of cancer of the larynx. *Med. Pr.*, 1946, 216, 6.

Cohen, Sol M. Democratic Nursing. *Lancet*, 1946, ii, 1.

Turner, J. M. Diagnosis and treatment of injuries of the semi-lunar cartilages of the Knee joint. *Med. Pr.*, 1946, 216, 25.

Garfitt, G. J. Maxillo facial injuries in children and their sequelæ. *Dent. Rec.*, 1946, **66**, 159.

Shaw, Maurice. Diagnosis and Treatment of chronic cholecystitis. *Proc. Roy. Soc. Med.*, 1945–6, **39**, 495.

Stebbing, G. F. Total war on Cancer. *Brit. Med. J.*, 1946, ii, 77.

Gleadow, E. F. An improvised closed circuit. *Ibid.*, 90.

Parfitt, J. B. Valedictory Address. *Brit. Dent. J.*, 1946, **81**, 35.

Rushton, M. A. Solitary lone cysts in the mandible. *Ibid.*, 37.

Marre, I. R. Infantile Eczema. *Post-Grad. Med. J.*, 1946, **22**, 190.

Camps, F. E. An outbreak of infection due to Salm. typhi-murium. *Brit. Med. J.*, 1946, ii, 131.

Change of Address

A. G. Charlton Cox, M.B., B.S., 23, Durham Avenue, Bromley, Kent.

F. L. Ingram, M.R.C.S., L.D.P., 9, St. Leonards Road, Thames Ditton, Surrey. (Tel.: EMB 3491.)

K. O. Rawlings, Major, R.A.M.C., 89, General Hospital, M.E.F. (1).

Deaths

CARTER.—On July 17th, 1946, suddenly at Bramble Hill, Honiton, Devon, Arthur Burnell Carter, M.B., B.Ch.

LAKEMAN.—On July 13th, 1946, in London, William S. Lakeman, L.D.S. R.C.S., of Westwater, Canford Cliffs, late of Uxbridge and Gerrards Cross.

EDS. {R.H.N.L. J.E.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LX No. 1515 *17th August 1946* *Ninepence*

PASSIM

TO be called upon to operate on a strangulated femoral hernia—in the middle of the night, with just an inexperienced anæsthetist and an inexperienced nurse in the theatre and only three weeks after qualifying—might, with justification, be regarded as something of an ordeal, even for a Guy's man. And this kind of thing is no rare occurrence for a house surgeon in a provincial hospital. The question at once arises, "Is it fair?" Is it fair on the houseman and is it fair on the patient?

How easy, and how dangerous, it is to say that a Guy's man is prepared to tackle anything. His medical training may be the best that this country can offer, but there is a world of difference between sound theoretical knowledge and sound practical experience. The gap must be bridged carefully and slowly. Most doctors wish to give their patients the finest possible treatment, and so a doctor of three weeks' standing might well agree that he was not fully competent to undertake a major operation on his own. It is asking him to bear too great a burden of responsibility, and, what is more important, the element of danger to the patient is not being reduced to a minimum.

We have said that these situations are not uncommon. Why do they arise? There is a very clear distinction between a London and a provincial hospital, and therein lies the answer. The busy or unscrupulous surgeon in the provinces (and unfortunately the latter do exist) is more inclined, particularly in the middle of the night, to allow nature to take her own course—the busy surgeon simply because he is worn out with fatigue and has another busy day ahead of him and the unscrupulous one because the man with the strangulated hernia is not a private patient. The houseman realises that nature has taken a definitely unencouraging course and so he operates.

This is not an attack on the doctors and hospitals outside London. We have no right and no desire to deliver a general onslaught. But we have been impressed by the quite considerable duties of the housemen in these provincial hospitals. They are often the only resident qualified men, which means that their off-duty hours are few and far between (perhaps a half-day every fortnight and an occasional week-end, which lasts from Saturday afternoon to Sunday afternoon); they are over-worked and under-paid (they probably receive less than the charwomen and work much harder and much longer); they are called up in the night three or four times each week and sometimes twice in one night; they may have to make decisions which would cause anxiety to the greatest surgeons and physicians. All this and more for the sake of experience? Good experience it may be, but good policy it certainly is not.

EDUCATION, as everyone knows, is a continuous process, starting in the cradle, reaching its *forte* in the 'teens and tailing off in a sort of *diminuendo* in the sixth and seventh ages. This process naturally receives a great fillip during the years we spend at the various seminaries of learning with which this country abounds, but the oft-repeated question, "Where were you educated?" can never be satisfactorily answered until we are reclining on our death-beds, and it is unlikely to be answered, let alone asked, then.

What, however, of the answer? "Charterhouse," "Roedean," "Marlborough," "Wycombe Abbey," comes the reply, for the Guy's student or nurse, who was fortunate enough to attend a Public School, finds delight in allowing an illustrious name to roll comfortably from the lips, recalling the while long, lazy, sun-drenched afternoons with the dull thud of ball meeting bat somewhere in the distance. And

those who were fortunate enough *not* to attend a Public School find equal, indeed greater, delight in informing their friends very thoroughly of this happy fact. Wherever education may end old boys and old girls, of course, know everything there is to know about everything the moment they leave school, especially about behaviour, chivalry, etiquette and manners; and they can talk for hours on tradition, prestige and all those queer, uncertain ingredients which make up the indefinable Public School spirit (or the Private, Elementary, Secondary, even the Preparatory School, spirit.) The young student, fresh from school, is extremely conscious of his potential ability and, in one inadequate word, his utter " correctness." *Noblesse oblige* and all that.

And now let's glance at the park here at Guy's any afternoon when it's not raining and it's not cold. Bare legs and bare arms seem to have been poured loosely on to the grass and left there in a puddle. The whole aspect is altogether unseemly and there appears to be little or no attempt to mask the instincts. Everything that goes on can be watched from Hunt's House, Nuffield House, The Medical School, The Nurses' Home, Shepherd's House and the Colonnade, and visitors walking through the park must obtain a somewhat dismal impression of modern methods of relaxation in public. At its best it is Margate, at its worst, Southend. The sternest critics of our behaviour at school—the little boys who had a " pash " and the little girls who had a " crush "—would have been horrified to see their heroes and heroines so carelessly strewn about and so entirely ignorant of the first principles of decorum. In short, to use a nasty phrase, it's not nice.

THE National Health Service Bill has had its Third Reading in the House of Commons and is due to receive the Royal Assent and to be placed on the Statute Book before the end of this first session in November. Before then it has an airing in the House of Lords, but the Bill is likely to become Law without any amendments. Its safe passage through the Commons was a foregone conclusion, but the interest shown in it by medical men appears to have dwindled. Its effects will soon be far-reaching, and it would be a terrible calamity if it found the medical profession in a state of unpreparedness. A shortened form of the contents of the Bill is obtainable from His Majesty's Stationery Office.

IT is with regret that we mention the deaths of two loyal and respected servants of the Hospital—Miss Bertha Martin, who was trained at Guy's and retired in 1940 as Lady Superintendent of Salomon's Centre, and Mr. Benjamin Richards, foreman of the Orthopædic Works Department. We include two appreciations of Mr. Richards in this issue.

WE should like to congratulate Messrs. Dick, Lewin, Maclean, Reeves, Stafford Clark and Strang on their success in the M.R.C.P. Examination, and Messrs. Bell, Bitton and Rose on obtaining honours in dental surgery in the Final B.D.S. Examination.

WE are sorry to announce the resignation of Mr. John Blundell from the post of Assistant Editor, and wish him every success and happiness throughout his career. We are pleased to welcome, as his successor, Mr. Raymond Hinde, who was appointed at a recent meeting of the *Gazette* Committee.

Some Impressions of Greek Surgery

BY H. F. LUNN, B.Sc., M.B., B.S., F.R.C.S.

ONE of the ancient Ionian philosophers believed that " change " was the basic and essential characteristic of all matter. His belief was well substantiated by all that we saw in Greece during the war. The roads beyond Athens have lost any form or cohesion they may have once possessed. Politics, the time-honoured hobby of the people, fill their conversation and their newspapers, provoking world-wide interest and confused comment. Little is said about Greek medicine and surgery. Much of the empirical art of the dark Middle Ages still persists beneath a façade of modern terms and methods. In the country districts we saw massive scarring from cupping, and many cases of sciatic paralysis from misplaced injections of quinine. Doctors crowd into the towns and leave wide areas of the country almost devoid of

medical care. In the few cities, the hospital buildings look more modern than our own, and their universities demand a similar standing of learning.

A medical student absorbs the tradition of his medical school, and we hope that sympathy and understanding of the patient will always be features of the British tradition. In Greece, however, there is a strong German element in their medical training. Their professors have often been students who availed themselves of pre-war opportunities to study in Germany at reduced rates. They would return, greatly impressed with German efficiency, ashamed of the petty confusion in their own country, and having found delight in making others feel small. I believe that this Nazi influence explains why their patients were so afraid of them, and why co-operation with them was not always possible.

Late last year I took over a small surgical unit in Petras, the fourth city in Greece, situated on the sheltered West coast. Snow-capped mountains lay behind the town and around the bay, rising steeply out of the sea. Across the water were the islands, independent little communities living in surroundings of great beauty, cut off from the war except for Service visitors. We were one hundred and fifty miles from Athens along a road which was supposed to be the best in Greece, but which took an ambulance a whole day to cover. We operated there on any Service case not fit to stand the ordeal of the journey to Athens, and I inherited a host of Greek civilian out-patients whose treatment my predecessor had begun.

It was difficult to operate on civilians in our small unit attached to a Field Ambulance, with limited equipment, and with no official means of keeping them in bed afterwards. They did not accept operations under local anæsthesia alone and, after even a minimal dose of pentothal, they had to be kept in a small side-ward overnight with the ever-present family retainers out of the way of military authority.

I began from the start to see whether it was possible to co-operate with the local Greek surgeons, and to have a few beds in the civilian hospital, which U.N.R.R.A. had set on its feet with a high degree of success. Soon after I arrived, I met a Greek surgeon in consultation about a case of appendicitis in a girl of sixteen. I agreed with his appreciation of the physical signs, but did not agree that operation could be safely deferred until the next day. He took out the appendix in his private " clinic " that evening. He did not close the peritoneum, but packed the wound. In spite of my fears, the child did very well. The parents had to find the currency equivalent of two hundred pounds, over half that amount being the cost price of the ether used.

As soon as I could, I transferred my clinic of civilian out-patients from the Field Ambulance to the Civil hospital. I saw some extraordinary conditions, and my Greek colleagues viewed the clinic with some disfavour. My patients were for the most part impecunious, and my frequent requests for beds threatened to reduce the income on which the hospital depended. It was not long, however, before all except the Professor, the senior surgeon and an old man of Prussian training and temper, became my friends.

I saw several cases there which might well have been on the list of those attending Queen's Square or other examination centres. A small boy, whose dorsal kyphosis was not easily seen until he removed his clothes, came up with a pear-shaped swelling above the medial side of his right knee. The lump was subcutaneous, fluctuant, and had slowly increased in size over eight months up to a mean diameter of twelve centimeters. It was a large cold abscess, secondary to his previous spinal caries, and presenting through the deep fascia of the thigh along with the medial femoral cutaneous nerve.

An old man one day pushed his way in, and removed a well-worn bandage from his head to display a huge rodent ulcer. The growth had extended over twenty years, and had destroyed the left eye and eyelids, both sides of the bridge of the nose, and had almost eroded the right eyelids. He only had a very limited range of vision with the right eye through a tiny gap in the granulations. We saw too many such cases who had not sought treatment until their condition was inoperable.

A youth, destitute, and unable to obtain any employment, would have done anything to be cured of the huge cavernous hæmangioma which replaced the right side of his face, and which was three inches thick, causing hideous deformity of the mouth. Its removal would have been a heroic procedure, and large flaps or pedicles would have been needed to reline the cheek and cover the face. The recent rapid increase in size made me wonder if operation was justifiable. It is probably fortunate that my

zeal to present the Gordon Museum with a historic specimen was curtailed by my return home.

Within the surgical wards of the hospital, the most frequent causes of admission were osteomyelitis and tuberculosis of bones and joints. I was disappointed to find so few beds used for emergencies, and so many filled with chronic disease. My interpreter was of more than average intelligence, and observed, " Our surgeons begin treatment well, but finish slowly," and later reminded me of the similar situation in English hospitals not so very many years ago.

Tuberculosis affected young and old, and appeared to run a more chronic course than in the British Isles. A woman of forty years, with extensive sacro-iliac disease and overlying cold abscess had noted very little increase of her pain and disability over the past fifteen years, and had not had to give up her housework. A girl of twenty-two with early infection of her left knee-joint, and with classical starting pains at night, refused to accept my diagnosis or my treatment, as she preferred to attend a wedding in the near future.

Osteomyelitis provided fearsome problems. One of the surgeons believed that the high incidence of secondarily infected scabies was responsible for its prevalence in Greece. I had studied scabies before leaving England, and had been impressed with the diminished resistance of the skin which accompanied even mild or latent infestation with the parasite. There was no doubt that scabies was endemic in Greece, though this was the first suggestion I had heard that it might feature in the aetiology of osteomyelitis.

Acute osteomyelitis was one of the diseases for which we were able to provide penicillin for civilian use. The Greek hospital staff quickly grasped the technique for its administration, and the results were excellent in the few cases I saw, where it was used for early osteomyelitis of the ilium. The patients who sustained the classical and radical operation of the Prussian-trained professor had an unhappy convalescence. The wide deep wounds were packed daily with flavine gauze, and soon acquired the common hospital strains of streptococcus, and discharged for months and years.

The ward dressing system was in striking contrast to the theatre technique, and took one's mind back to the Middle Ages. In keeping with current practice in Greece, the surgeon does all his own dressings. Nobody wears a mask, and the same set of instruments and jaconet sheets are used for each dressing. A relatively clean nurse dips the instruments into spirit between each patient, and a really dirty nurse rubs over the jaconet sheets with a spirit swab. I know that I am not alone in hoping to see shortly the end of further trust in the mysterious power of spirit as an immediate sterilising agent.

Not every wound received this painful and regular attention. There were many examples of clean healing by first intention. Herniæ, appendices, and Cæsarean sections usually healed well after operation. Thiersch grafts were done adequately, and were left undisturbed for ten days, unless fever ensued. Hydatid cysts were relatively common, and one huge cyst had been successfully removed from a lung.

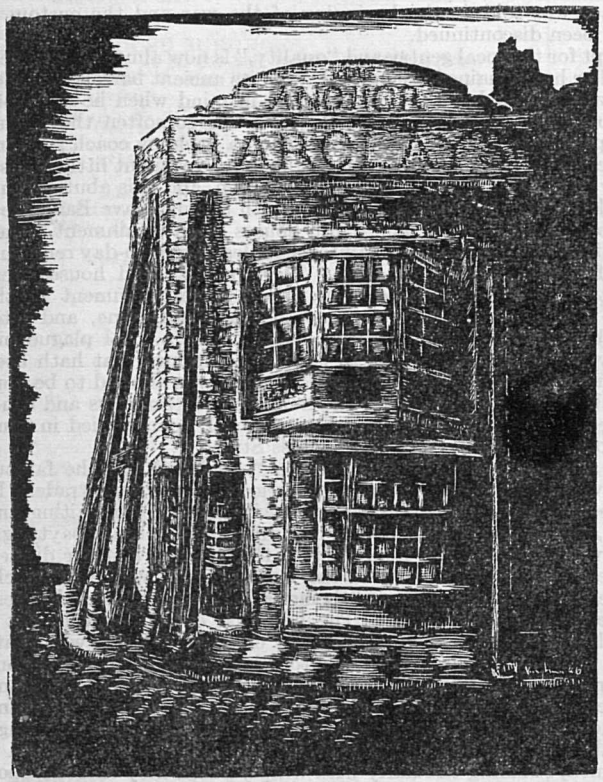
In the operating theatre there was a genuine effort to maintain true asepsis. There were a few weak points, but no major errors. The use of sterile water for scrubbing-up made it difficult to use sufficient, without depleting the supply for the list. Sterilisation was along similar lines to our own hospitals. They autoclaved their gloves in the same drums as the towels and gowns, thus ruining more pairs in one afternoon than I was able to obtain for a month. Instruments for the whole list were served up and pooled on a large trolley at the back of the theatre. The theatre sister did not scrub up. She was too valuable as an anæsthetist. She induced with evipan, and followed with open ether. She had no airway, and did not seem to need one. She had that intuitive sense, found in expert anæsthetists, which enabled her to leave the patient's head while she fetched lotions or sutures for the surgeon, always to return in time to maintain the plane of anæsthesia.

I have written at length of what I found in this corner of Greece, because, in spite of reports to the contrary, it showed that a reasonable standard of efficiency could be attained, at least under British and American influence. This unfortunate country, occupied in turn by the Turks and the Nazis, with a climate that is colder than Scotland in winter, and as hot as Egypt in summer, will surely benefit from the understanding and support of her medical services, which she is at present receiving.

Bankside—"The Anchor"

By G. F. VAUGHAN.

"SIR, we are not here to sell a parcel of boilers and vats, but the potentiality of growing rich beyond the dreams of avarice." This was the opinion of Dr. Johnston in 1781, when the ownership of Mr. Child's "Anchor" Brewery and Tavern came to Mr. Barclay. More than 150 years have passed, and now, in 1946, we in turn might pay tribute to this tavern whose history is the history of Southwark.



The "Anchor" is to us what the old "Ship and Shovel" was to the pre-war student, and thanks are due to Mrs. Moye and, through her, to the many friends we have on Bankside, for all the pleasant evenings spent there. For this is "Our Pub," reminding us of many incidents; small parties, quiet meetings between friends, the new puppy drinking his evening "bitter," or even the well-known gentleman, who, slightly the worse for wear, dived gracefully into the muddy Thames.

To the "Anchor," however, we must be only a small episode in its long history, for many famous men have preceded us, leaving behind them fragments of character which, blending with that of Southwark itself, have developed the present atmosphere.

The Rose, Globe and other Theatres were situated nearby, so actors and poets once filled the bars. Shakespeare and Massinger and many others came here to taste the ales that made Southwark so famous.

"The nappy strong ale of Southwirke
Keeps many a gossip from the kirke."

In a later age Dr. Oliver Goldsmith struggled hard to run a practice on Bankside. His lack of success seems to have been noticed, for his contemporaries recorded that he indulged in a shabby suit of green and gold, "while a want of neatness and of money for the washerwoman was clearly betrayed in his shirt and neckcloth, often of a fortnight's wear." Compelled to carry his hat over his left breast, to cover a large patch in his clothes, he was involved in at least one embarrassing moment. A patient tried to relieve him of it, causing him in his consternation to "press it even more devoutly to his heart." His technique for examining patients in this one-handed fashion was not related.

More notorious, perhaps, was the last of the barber surgeons of London. A Mr. John Timbs records: "I may add my remembrance of his shop-window, with its heap of drawn teeth and the barbers pole at the door. His name was Middleditch, and, *renovere dolcrem*, I have a vivid recollection of his dentistry."

No less interesting than the customers is the building itself, which stands now almost unaltered since the 17th century, when it was built to replace a burnt down predecessor. It is second only to the "George" for antiquity. Most of the interior is also in its original form for there have been very few changes. It was used for smuggling, the double walls probably being built for this purpose. It has its ghost and also a secret passage. Unknown to most of us, there is a large panelled room upstairs. Dating certainly no later than 1750, this room has five entrances with steps and double doors, and it is from here that the old secret passage leads down under the roadway to the foreshore.

The dart room was the old kitchen, once noted for its meals, and now less glorious, since the original fireplace was sold at the beginning of the war and the custom of "sanding" the floor has been discontinued.

The small side bar, kept for the local gentry and "quality," is now almost exclusively a Guy's bar. The main bar has remained unchanged, with its ancient barrels and snug appearance. Surely, it was such a bar that Dickens had in mind when he described the Six Jolly Fellowship Porters of Southwark. ". . . a bar to soften the human breast. The available space in it was not much larger than a hackney coach; but no one could have wished the bar bigger, that space was so girt in by corpulent little casks."

The "Anchor" site lay in the Bishop of Winchester's Garden, and this abutted on a line of brothels, the Bordello, or "stews," which in the 15th century gave Bankside a notoriety it was never to lose. Described as "damp houses of entertainment," they were licensed under the Bishops. Each had its painted sign, leaving us to-day remnants such as Cardinals Wharf and Cardinal Cap Alley. These twenty odd houses were liable to certain regulations, infringement of which led to imprisonment in the ecclesiastical prison, the dreaded "Clink" at the corner of Maid Lane, and later removed to a more morbid spot, Deadman's Place, named after a local plague pit. The houses were vaguely licensed, "accordinge to the olde customes that hath been vsed and accustomed tyme out of mynde." No single woman was allowed to be kept there against her will; all were "voyded out of the lordship" on Sundays and other holidays. They were even denied any rights of Christian burial, being buried in communal graves at Cross Bones, now the corner of Redcross Street.

Perhaps the greatest single source of custom for the "Anchor" was the famous Bear Garden. Lying in what is now the Brewery, it carried on a thriving trade. In 1591 a Royal Charter decreed that Thursdays be set apart for the bear baiting and such pastimes, described, by the way, as "bowell-baytyng" and "beare-baytyng." Both Pepys and John Evelyn make many references to this Garden in their diaries. The latter wrote on June 16th, 1670, "I went to the Beare Garden where was cock-fighting, dog-fighting, beare and bull-baiting, it being a famous day for all these butcherly sports, or other barberous cruelties. The bulls did exceeding well, but a wolfe-dog exceeded, which was a tall greyhound, a stately creature indeede, who beate a cruell mastiff. One of the bulls toss'd a dog full into a lady's lap as she sat in one of the boxes at a considerable height from the arena. Two poore dogs were kill'd and so all ended with an ape on horseback, and I most heartily weary of the rude and dirty pastime." Some idea of the savagery of these displays is given by the following: "to this entertainment there often follows that of whipping a blinded bear, which is performed by five or six men, standing circularly with whips, which they exercise upon him without mercy."

One last fragment may be of interest, again from John Evelyn's diary, this time in September, 1666, and probably seen from the very door of the old "Anchor."

"The fire continuing, after dinner I took coach with my wife and sonn, and went to Bankside in Southwark, where we beheld the dismal spectacle, the whole city in dreadfull flames neare the water side; all the houses from the Bridge, all Thames Street and upwards towards Cheapside, down to the Three Cranes, were now consumed. The poor inhabitants were dispersed about St. George's Fields and Moorfields as far as Highgate, and severall miles in circle, some under tents, some under miserable hutts and hovells, many without a rag or any necessary utensils, bed or board, who from delicatenesses riches and easy accomodation in stately well furnished houses were now reduced to extremest misery and poverty."

These extracts and thoughts of men long since dead, fragments from here and there, form a picture of countless lives and incidents which blend with the surroundings of to-day. Maybe as you walk down Bankside, and see "Clink" marked on the leaning posts, notice the battered tottering walls of the "Anchor" with its sloping windows and its many shoring pins, see an initial carved in the panelling, or follow the cracks and seams in the woodwork, remember the days that are past and see the ghosts of the centuries as they flit across your pathway, wandering among the shadows of their memories.

House Appointments

AUGUST 1st—OCTOBER 31st, 1946.

	Remaining	*New Appointments*
GUY'S.	HOUSE PHYSICIANS.	
	Joiner, C. L.	Still, H. C.*
	Finnegan, T. R. L.	Bucknall, C.*
	Martin, J. K.*	Lloyd, G. H. T.*
		Craig, R. A.*
		Price, T. M. L.*
	HOUSE SURGEONS.	
	Dickson, J. R. (to Mr. Massie and Mr. Wass).	
	Robinson, R. G.* (to Mr. Davies Colley and Mr. Brock).	
	Rey, C. H. J.* (to Mr. Slesinger, Mr. Eckhoff and Genito-Urinary Department).	
	McLaren, L. R.* (to Sir Heneage Ogilvie and Mr. Atkins).	
	RESIDENT OBSTETRICIANS.	
	Holman, J. G.*	Horan, D. G.* (from 1.9.46).
	Rees, D. D. L.*	
	OUT-PATIENT OFFICERS.	Missen, G. A. K.
		van't Hoff, W.
		Bulleid, J. A.
		Delafresnaye, J. F.
	DERMATOLOGICAL HOUSE PHYSICIAN.	
	Kustow, B.*	
	CHILDREN'S HOUSE PHYSICIANS.	Vulliamy, D. G.*
		Dawe, E. B.*
	NEUROLOGICAL HOUSE PHYSICIAN.	Maile, W. B. D.*
	THROAT AND EAR HOUSE SURGEON.	Bull, J. P.*
	OPHTHALMIC HOUSE SURGEON.	Lane-Roberts, P. A.*
	BACK SURGERY.	
	Pearson, G. M.*	
	FRACTURE HOUSE SURGEON.	
	Rochford, J. P.*	
	RESIDENT PATHOLOGIST.	
	Luder, J.	
ORPINGTON.	HOUSE SURGEONS.	
	Mills, R. P.*	
	Burns, T. H. S.	
	Goulder, R. V. H.	
	HOUSE PHYSICIAN.	Trusted, H. W.
PEMBURY.	HOUSE PHYSICIANS.	
	Neville, N. A.*	Jefferson, K. E.
	HOUSE SURGEONS.	
	Coling, P.	Backhouse, H. L.
		Haas, L.
FARNBOROUGH.	HOUSE SURGEON IN RECEIVING ROOM.	Watts, C. H.*
	HOUSE SURGEON.	Griffin, B. P.*
	HOUSE PHYSICIAN.	
	Wilks, J. M.	
	HOUSE PHYSICIAN IN SPECIAL DEPARTMENTS.	Pinching, J.*
SOUTHERN.	HOUSE SURGEONS.	
	Pearson, C. M. G.	Brunsdon, D. F. V.
	Bearn, A. G.	
	Hutchison, J. G. P.	

* Ex-Service

HOUSE OFFICERS RETIRING.

Guy's	*Orpington*	*Pembury*	*Farnborough*	*Southern*
Allanby, K. D.	Parry, T. C. L.	Cree, W. W.		Ward, M. W. P.
MacVicar, G.*	Dixon, H. G.	Shaw, C. S.		Woodman, G.M.
Buckler, F. R.*		Crook, J. C.		Bayliss, J. C.
Cole, C. K.*		Topham, H. W.		
Cormac, C. D.*				
Jenkins, J. T. M. C.*				
Lewin, D. C.*				
McLean, K. S.*				
Stafford Clarke, D.*				
Stewart, I. Mc. D. G.*				
Blundell, J. E.				
Scott, L. G.*				
Stone, A. W. P.*				

* Ex-Service.

Hospital Appointments

MEDICAL SCHOOL

The following appointments were made by the School Council on Tuesday, 16th July, 1946 :

Medical Registrar.
D. N. Leeming, M.R.C.S., L.R.C.P., for one year.
N. Southwell, M.R.C.P., for one year.

Acting Medical Registrar.
J. C. Houston, M.R.C.P., for one year.
S. H. Llewellyn Smith, M.R.C.P., for one year.

Surgical Registrars.
A. J. Drew, F.R.C.S., for two years.
C. P. Nicholas, F.R.C.S., for two years.
R. E. Horton, M.B., B.S., for one year.
B. G. A. Lilwall, F.R.C.S., for one year.

Registrar in the Children's Department.
C. W. Kesson, M.R.C.P., for two years.

Surgical Clinical Tutor.
P. W. Clarkson, F.R.C.S., for one year.

Orthopædic Registrar.
J. H. Mayer, F.R.C.S., for one year.

Obstetric Registrars.
T. L. T. Lewis, F.R.C.S., for two years.
H. A. Ripman, M.B., B.S., for two years.

Lecturer in Diseases of the Blood.
R. L. Waterfield, M.R.C.P., for five years.

Lecturer in Pathology.
S. J. de Navasquez, D.M., for five years.

Assistant Lecturer in Pathology.
K. J. Randall, M.B., B.S. (Griffiths), for one year.
N. Ambache, M.R.C.S., L.R.C.P., for one year.

Demonstrators (part-time) in Pathology.
W. St. C. Symmers, M.B., B.Ch., for one year.
G. P. Baker, M.B., B.Ch., for one year.

Gull Student in Pathology.
J. O. Laws, M.B., B.Ch., for one year.

Assistant Lecturer in Anatomy.
H. R. S. Harley, M.S., for one year.
G. P. A. Sechiari, M.R.C.S., L.R.C.P., for one year.

Demonstrator (whole-time) in Anatomy.
G. D. Channell, M.B., B.S., for one year.

Demonstrator (part-time) in Anatomy.
R. T. Hinde, M.R.C.S., L.R.C.P., for one year.
D. M. Strathie, B.M., B.Ch., for one year.

Assistant Lecturer in Physiology.
E. O. Hohn, M.B., B.S., for one year.
J. N. Hunt, M.B., B.S., for one year.
L. C. Thomson, M.B., B.S., for one year.

Assistant Lecturer in Chemistry.
W. L. G. Gent, B.Sc., for one year.

Demonstrator in Chemistry.
M. E. Foss, B.Sc., for one year.

Lecturer in Physics.
C. B. Allsopp, Ph.D., for five years.

Assistant Lecturer in Physics.
W. J. R. Calvert, M.A., for one year.
A. H. Walker, Ph.D., for one year.

Demonstrator (part-time) in Physics.
C. W. Wilson, Ph.D., for one year.

Lecturer in Biology.
E. W. Baxter, B.Sc., for five years.

Assistant Lecturer in Biology.
B. J. Rickard, B.Sc., for one year.
Demonstrator of Dental Mechanics and Prosthetics.
R. J. Wheatley, L.D.S., for one year.
J. W. Mansie, M.R.C.S., L.D.S., for one year.
R. D. Gain, L.D.S., for one year.
K. P. Liddelow, L.D.S., for one year.
Half-time Assistant to Director of Conservation Room.
R. O. Holland, M.R.C.S., L.D.S., for one year.
A. D. Robinson, B.D.S., for one year.
Demonstrators of Operative Dental Surgery.
G. S. Loader, L.D.S., for one year.
H. H. Kenshole, L.D.S., ,,
A. R. Thompson, B.D.S., ,,
W. A. Vale, B.D.S., ,,
C. I. Hagger, L.D.S., ,,
R. F. Pusey, B.D.S., ,,
J. G. Hancock, B.D.S., ,,
Half-time Assistants in the Department of Preventive Dentistry.
W. G. Cross, B.D.S., for one year.
R. D. Emslie, B.D.S., for one year.
Demonstrator of Dental Histology.
J. W. Mansie, L.D.S., for one year.

Appointments to date from 1st October, 1946.

(*A further list of Hospital Appointments will be published in a later issue.*)

Appreciations

BENJAMIN RICHARDS.

ALL Guy's men will have learnt with great regret of the sudden death of Richards. Surgical appliance maker to Guy's since 1920, his natural dignity and courtliness endeared him to all, and we will miss his familiar figure as, usually in shirt sleeves, he went about his work in the Hospital.

Richards belonged to a breed of workmen which seems to be fast disappearing—the skilled craftsman versed in the lore of his trade. Each splint was to him a piece of apparatus specially designed for an individual patient, and he would not allow the high standard of his craft to be lowered by hurry in the execution of his work. He stoutly resisted any form of mass production or standardisation and remained serenely undisturbed by the quickening tempo of modern life.

His sturdy and independent outlook was reflected in the appearance of his workshop, which to the casual observer presented an inextricable jumble of all types of splints and apparatus in various stages of construction and repair. To many it seemed impossible that any splint that joined this untidy array could ever be found again—but Richards knew where it was. Indeed, when I once suggested to him that a shoe had been lost in his workshop he was quite taken aback, for he stoutly maintained that no such thing had ever been known to happen throughout his many years at Guy's.

Those of us who knew him well had noticed during recent months that he was not quite his usual robust self. There is no doubt that the war years must have been a severe strain, for his duties in the Sector involved a great deal of travelling and an enormous increase in the amount of work he had to accomplish in his cramped quarters at Guy's. A short time ago he told me how much he was looking forward to his coming retirement, and it is sad to think that he has been denied this well-earned reward for his labours. His death means the loss to Guy's of a skilled instrument maker and of a loyal and respected servant.

J. S. B.

It is with the greatest regret that we at Orpington heard of Mr. Richards' sudden death last week. As the Surgical Appliance Maker of Guy's he had very considerable work at Orpington, where we house so many orthopædic cases.

He was always so helpful, cheerful and considerate, and he will be greatly missed. His work was consistently successful, and Richards was always so co-operative in any difficulty which might arise in any special case.

I felt urged to write this appreciation as many people actually at Guy's might not realise how much valuable work he did, and what considerable time he spent in coming here.

He worked so hard that I fear he contributed in that way to his untimely death.

E. A. S.

Correspondence

The Heraldry of Guy's Hospital

SIR,—In Mr. Hooper's excellent article I notice that the official blazon of the Achievement mentions three leopards' heads whereas they are actually emblazoned as three leopards' faces.

In Heraldry a leopard's head is always depicted with part of the neck visible, which may be either couped or erased. Also it is assumed to be "in profile" unless blazoned "affronté."

A leopard's face is always depicted exactly as seen on the Guy's shield; that is, affronté with nothing but the face visible, and must be blazoned "a leopard's face," thus preventing confusion with "a leopard's head."

Yours faithfully,

Clydesdale, Hersham Road, C. W. TURNER.
Walton-on-Thames.

SIR,—I was greatly interested in the recent article in the *Gazette* by Mr. Hooper. Heraldry is a Science, possessing a highly specialised terminology, and bound by a systematic series of rules, and whatever is to be expressed in Heraldic symbolism should be as accurate and concise as possible. There are no grounds for the adoption of a Peer's helmet in the Achievement of the Hospital—I have found no mention of such a helmet being granted in any of the records at the College of Arms. For the completion of an Heraldic design a helmet is necessary and I would suggest that we would be more correct in adopting that which belongs by right to an Esquire, *i.e.*, "one closed steel helmet facing dexterwise."

Yours, etc.,
R. A. BRUCE.

London, S.W.16.

St. Thomas's Hospital and the Borough

SIR,—I read with very great interest Mr. Brock's article in the last issue of the *Gazette*, having been associated with the Borough and Guy's for the past fifty years.

Mr. Brock mentions "Borough High Street" (which incidentally was to have been named "Wellington Street"). I would point out that Wellington Street was actually so named and I have lately turned out a steel engraved plate showing the premises of Ash & Co. at the corner, now occupied by the Westminster Bank, the address being 5, Wellington Street, also showing the front garden of St. Thomas's Hospital.

I should put the date about 1825, and at that time the business was carried on on the ground floor and the family lived above.

It may interest you to know that this business was started in 1795 in Adams Place, Borough, so that it is now operating within a mile of its original premises.

Yours faithfully,
FRED MASON.

Holyrood Street,
London, S.E.1.

Eye Trouble in the Front Surgery

On Front Surgery card received in the Eye Department:—

"F.B. in R. Eye?"

Same card received back in Front Surgery:—

"F.B. in R. Eye?"

"No, B.F. in F.S."

Young female patient;—"I haven't seen anything now, doctor, for two months."

Junior dresser;—"Oh dear, then I'll send you straight up to the Eye Department."

Review

The Sulphonamides in Theory and Practice. By J. Stewart Lawrence, M.D.(Ed.), M.R.C.P. First Edition. H. K. Lewis and Co. *Price* 9*s.*

FOR those who like to know the exact properties and true possibilities of the therapeutic substances they prescribe, this is an excellent little book. The spate of literature on the sulphonamides is tending to wane and as we pass to a period of consolidating knowledge already gained, it is valuable to have before us a brief survey of the established facts.

After comparing and contrasting the various available chemicals of this group, the author describes their relative potency as regards different infections and then passes to a chapter which is purely pharmacological. From this sequence the clinical reader receives much good guidance as to which drug should be selected in particular conditions.

The selection made, the principles of day-to-day treatment are considered, also dosage for children and precautions and contra-indications. The review then takes a bacteriological turn pointing to various possible future developments before returning to a very practical chapter in which infections are dealt with on a regional basis and the urinary tract, respiratory organs, eyes, ear, nose and skin are considered in that order.

After the early war-time enthusiasm for sulphonamides in wound treatment, Chapter VII on traumatic surgery makes interesting reading and, for future guidance, gives a well balanced picture of the results. Finally, the sections on common abuses of the sulphonamides and a comparison with penicillin bring to a close a concise review which to both clinician and bacteriologist will be of real value. F.A.K.

Sport

Tennis Club

This is the first report of a very full season from the Tennis Club. Three events deserve special mention.

First is the welcome news of a renewal of the annual match against Prof. Johnston's team. Playing under ideal conditions, the club won 7 matches, lost 1, and one match was left unfinished. The opposition from 9 players was quite keen.

Prof. Johnston's IX were Prof. Johnston, Prof. MacIntosh, Sir John Conybeare, Dr. Guy Cooper, Mr. Eckhoff, Mr. Stamm, Mr. Lewis, Dr. Stafford Clark and Dr. Stewart.

The second match of note was in the semi-final round of the Inter-Hospitals Cup. We beat London Hospital by 8 matches to 2 out of 15 matches.

Team : P. J. Dwyer, K. Y. Khong, R. Freeman, I. Kelsey Fry, E. J. Filose, P. Carton-Kelly.

Finally, we are glad to announce the conclusion of the Lane-Washbourn Cup Tournament. This was last held in 1939. P. J. Dwyer, captain of the tennis club, played consistently good tennis to win the championship.

Score : Semi-Final—P. J. Dwyer bt. K. Y. Khong 6—1, 8—6. R. Freeman bt. A. R. Merrill 6—3, 6—3.

Final : P. J. Dwyer bt. R. Freeman 6—2, 6—4.

K. Y. KHONG.

Hospital Information, etc.

Pass List

ROYAL COLLEGE OF PHYSICIANS.

July, 1946.

M.R.C.P.

R. C. S. Dick, M.B., Camb.
D. C. Lewin, M.B., Lond.
K. S. MacLean, M.B., Camb.
T. L. Reeves, M.B., Lond.
D. Stafford-Clark, M.B., Lond.
R. P. Strang, L.R.C.P.

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH.

July, 1946.

M.R.C.P.

A. Rabinowitz

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

F.R.C.S.

PRIMARY EXAMINATION.

May, 1946.

R. T. Hinde

UNIVERSITY OF LONDON.

SECOND EXAMINATION IN DENTAL SURGERY.

PART I.

July, 1946.

Pass.

W. J. Bailey
R. McK. Carson
J. D. Devry
H. E. Dyer
J. C. Farrow
N. R. Howells
J. H. Keeling
P. B. Morris
T. C. J. Price
A. A. Robinson
A. H. R. Rowe
C. B. H. Watson
J. G. Whitelegg

The following Students are credited with Anatomy and Physiology :—

D. R. Boswell
B. G. E. Donner
A. L. Giulianotti
P. Glazebrook
P. T. Grimer
M. Kaye
M. M. Keen
P. J. A. Lawrence
L. A. Rees
J. D. R. Shaw

The following Student is credited with Prosthetic Dentistry including Metallurgy :—

T. K. Walker

UNIVERSITY OF LONDON.

SECOND EXAMINATION IN DENTAL SURGERY.

PART II.

July, 1946.

Pass.

J. L. Attenborough
R. A. Dean
C. N. Furnivall
J. B. Harris
S. P. Johns
A. Levy
*R. A. J. Mayhew
*J. D. Morgan
L. G. Richards
L. A. Rosen
P. H. Smith
*W. J. Tulley

* Awarded a mark of Distinction.

THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.

July, 1946.

Honours.

*S. J. Bell
*B. M. Bilton
*J. S. Rose

* Distinguished in Dental Surgery, Operative Dental Surgery.

Pass.

S. F. Lamb
R. A. Morsman
A. K. Parsonage
A. Rooms
P. G. Shingler

Supplementary Pass List.

The following Student has passed in Group I. :—

A. Stone

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

July, 1946.

Surgery.—H. Freeman.
Midwifery.—W. F. Belsham, K. Y. Khong.

Appointment

Venerable Order of the Hospital of St. John of Jerusalem.

Officers.—Capt. R. S. Harper, C. G. Roberts.

Serving Brother.—Dr. A. B. Davies.

Papers by Guy's Men

Van Meurs, D. P.. Ileocolic intussusception associated with non-rotation of the mid-gut, congenital heart disease, and congenital hydrocele. *Brit. J. Surg.*, 1945–6, **34**, 91.

Blacker, C. P. Galton's outlook on religion. *Eugenics Rev.*, 1945–6, **38**, 69.

Rushton, M. A. The application to civilian practice on some Dental lessons of the last war (4), E.M.S. *Brit. Dent. J.*, 1946, **81**, 78.

Hale, H. D. Two unusual cases of necrosis of the jaws. *Ibid.*, 83.

Cutler, Robert. Acrylic jacket crown technique. *Ibid.*, 83.

Batchelor, J. S. Zygomatic traction for fracture of cervical spine. *Lancet*, 1946, ii, 202.

Change of Address

A. Batty Shaw (363774), Lt. R.A.M.C., 2nd Parachute Batt., M.E.F.

J. D. Buxton, Major R.A.M.C., No. 9 (Rissen) British Military Hospital, B.A.O.R.

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W. H. West, L.D.S., R.C.S., Glenbrook, 63, Hersham Road, Walton-on-Thames.

Births

BAILY.—On July 30th, 1946, at Nuffield House, to Betty (née Longmire), wife of Surg.-Lt. R. A. Y. Baily, R.N.V.R.—a daughter.

BARBER.—On 23rd July, 1946, at Nuffield House, Guy's Hospital, to Edna (née Eaves), the wife of Norman L. Barber, L.D.S.—a daughter (Eve Gladys).

GRAY.—On July 23rd, 1946, at Antrim House Nursing Home, to Patricia (née Parke), wife of J. Allan Gray.—a daughter (Stephanie Parke).

O'KEEFE.—In July, 1946, at 235, Jan Smut's Ave., Parktown-North, Johannesburg, S.A., to Mary Constance O'Keefe (née Pegum), wife of J. O'Keefe, L.R.C.P. M.R.C.S.—a son (Stephen John Dennis).

Marriages

GALLOP — HARRISON OSBORNE. — On July 20th, 1946, at St. Peter's, Leckhampton, Maurice F. Gallop, M.R.C.S., L.R.C.P., of Tunbridge Wells, to Nancie (Ann) Harrison Osborne, C.S.P., of Cheltenham.

HOUSTON—CRUICKSHANK.—On 15th August, 1946, in York, James Caldwell Houston, M.D., M.R.C.P., second son of Mr. and Mrs. David Houston, late of Finchley, to Thelma Cromarty Cruickshank, M.B., Ch.B., second daughter of Professor J. Cruickshank, C.B.E., M.D., of Aberdeen.

Deaths

MARTIN.—On August 6th, 1946, at Kilmorna, Bulphan, Essex, Bertha Martin, R.R.C., Lady Supt. Salomons Centre, 1919-40.

RICHARDS.—On July 29th, 1946, in Guy's Hospital, Benjamin Richards, Foreman Orthopædic Dept. 1920-46, aged 69 years.

SLATER.—On July 30th, 1946, at Godalming, William Arnison Slater, M.R.C.S., late of Guildford and Haslemere.

EDS. {R.H.N.L. R.T.H.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

LOP off the branches of an ancient oak. Its outline is changed. After a spell, new branches appear. The oak lives on.

So with great corporate bodies; so with a great hospital. When from its midst the famous depart others take their places and the hospital lives on. For it is greater than its greatest sons.

With sorrow we bid farewell to two of our Honorary Staff. Dr. Mutch, lately our senior physician and Mr. Davies-Colley, recently our senior surgeon, have retired from active work. Both have served Guy's faithfully in the matchless tradition of their family connections. Mrs. Mutch is the daughter of the late Sir William Arbuthnot Lane and Mr. Davies-Colley's father was himself a former surgeon to the hospital.

On behalf of all who have come under their influence as teachers and exemplars, we thank Dr. Mutch and Mr. Davies-Colley that in giving of their best, their names will be ever remembered where Guy's men meet and talk. During the difficult war years they held an important outpost of our hospital. All who were with them at Farnborough have testified that they held it with distinction.

We wish these two eminent men a happy, long and well-earned retirement.

IT is being said that there is talk of the formation of a political society at the hospital. The particular brand of this one is thought to be conservative in flavour and bias. Now this may be no more than rumour. But it must be remembered that rumour, gossip and tittle-tattle mean as much at Guy's as the thudding tom-tom in the African bush. Hole-and-corner hearsay is our recognised way of communication, and what begins as a confidential whisper nearly always ends as a *fait accompli*.

We view, therefore, this latest information with some misgiving. It is not the first time that one form or another of political club has been entertained, though on previous occasions mis-carriage on infanticide has usually terminated the pregnancy. The desire by men, who think at all, to form political associations is not unnatural; it is, indeed, praiseworthy. However, in our view, the indulgence of this desire in a teaching hospital must be qualified by the special circumstances of our profession.

There is some point in observing that in the Concise Oxford Dictionary the word "politic" is defined as an adjective thus: "judicious, expedient; scheming, crafty." The first pair of words changed into nouns fairly describe "politics"—the science and art of government. But when we come to "party politics" it is only too true that both pairs of words are applicable.

Doctors, to-day, are becoming, more and more an instrument not of politics—they have always been that—but of party politics. To us, it seems that our profession should, as the Church ought to, stand quite apart from party politics using its independence of judgment, with which the practise of medicine endows it, as and where it is sought or where a moral obligation demands it. If it does not do that it forfeits deservedly the esteem that its special qualities and knowledge earn for it. There is little enough independent thought to-day and we can ill afford to cast away the last vestiges.

On the whole, the doctor who embraces party politics cuts a poor figure. His education has left him a little too honest for success, his knowledge of affairs is frequently shallow and his failure in practice has sometimes provided the motive for the step he has taken. Only a few, a very few, of our profession have become front-rank politicians and when we look at them we may be entitled to wonder what sort of doctors some of them were. The British Medical Association, in its negotiations at the present time, seems to have adopted the conventions and vulgarities if not the tenets of a political party, and how much this misfortune is due to its having a secretary who stood as a candidate at the last General Election, we do not know.

This, then, is why we wish no good to the deliberations, if any there be, of those who are said to be conceiving some new society of the kind we have mentioned. Here, at Guy's, it is doctors that are trained; and the chance that the hospital might nurture one outstanding statesman is too small to encourage the creation of a dozen second-rate back-benchers who in their spare time are indifferent doctors. Most of us know the "politically-minded" student, as we call him. A crabbed, hunted, stunted creature; full of prejudices and incapable of independent thought or action. By reason of the votes of his like-minded friends, for unfortunately all the others stay away, he finds himself on all the committees for which he is eligible. Once there, he exhibits himself as a paltry doctrinaire, seeing the issues before him not in the light of what is best for the hospital or its community but through a glass smoked by someone elses pre-conceived ideas. This poor fellow has chosen the wrong profession. Medicine has no place for him.

All this is not to say that as individuals we must not have our politics. We must, of course. And it is a duty that we should; even to choosing the least of the evils offered us at a General Election and by the generosity of a universal franchise.

A YEAR or two ago there was great excitement and enthusiasm. A new rebuilt Guy's had been planned. There was a model on show which would have accelerated the heart of any schoolboy. It would be the last word in hospital building and would cost the earth. Steps were taken to find the money for the great project. High hopes abounded. When they took off the shroud from Thomas Guy to mark the Victory, he had a smile upon his face. Even senior members of the staff hoped to see the great achievement in their lifetime.

Alas, things being as things are, we have awakened to find it all a dream though, one day, we know it will come true. Just when, no one can say. We have heard mentioned multiples of ten years and seldom a day less. Some say the venture is like the South Sea Bubble, so important a feature in our Foundation. And like that we do not talk of it. It has become as impolite as mentioning Baillie Stewart to a Gordon Highlander.

After all, we ought to be content. We can still sit among our heap of ruins and think of the hospital as it was before the wounds of war were inflicted and before our own sensibilities became blunted. In those days we used to grumble about all sorts of things.

Shortage of beds was one. Now, bombardment has made both the beds and our memories shorter. Prior to nineteen thirty-nine, if any one had suggested that Martha ward should be converted into a sort of Burlington Arcade to reduce the number of beds by forty, he would have been thought ripe for the York Clinic, had we had it then. Yet this has happened—forty beds less. And the compensation? Why, our bank has premises therein; and we hope for a barber's shop and a tobacconist who stocks cigarettes.

We used to complain of the breath of that monstrous belching dragon, the works department chimney. But even that was good for our nervous system if not for our lungs and our clean collars. For the pall of smoke beneath which we had lived steadied us when we saw those pictures, a year ago, of atomic mushrooms over Nagasaki and Hiroshima. We are accustomed to such mushrooms here in the Borough.

And do you remember the College? Scarcely a Passim was written, but the evils of its squalor and the meanness of its accommodation were not portrayed. Now we realise it was all exaggeration. We were growing spineless and used to soft living. The Luftwaffe could not destroy so splendid an edifice, try as it did. To-day the College is reopened and good for another fifty years or more.

And the Park? Perhaps, we were unimaginative then. For we never saw all those romantic things taking place out there that were illustrated in our last number. Of course, we had not the advantages of natural cover then; no overgrown rockeries; no wooded bunkers; no impassable undergrowths; not the delightful jungle battle-school atmosphere which characterises the park to-day. Now we can sit by the side of the deadly night shade, which we grow for physic, and watch the children of Bermondsey carrying off the leaves to dilate their pupils and add lustre to their eyes, like the fine ladies of Venice in the sixth century.

These and other things have taught us to find within ourselves extraordinary powers of self-adaptation, Nature's gift to *homo sapiens*.

As soon as possible it is hoped to dress the *Gazette* in its demobilisation suit with turned-up trousers and full length sleeves.

Even if, during this year, we are able to obtain the extra paper required for full-sized pages, it will be impossible to make the change until the current volume is complete owing to the uniformity necessary for binding it. Meanwhile copies are now available for all the nursing staff and massage and electrical students who have previously had to go without.

The Concept of the General Practitioner in the Dental Treatment of Fractures of the Jaw

A Lecture delivered in the Anatomy Theatre at Guy's Hospital on February 19th, 1946, to the Dental Society by

V. HENRY JEKYLL, D.D.S., L.D.S., R.C.S.

GENTLEMEN,—With your indulgence a moment I will take this opportunity to voice my gratitude to those who sponsored my coming amongst you to study, and particularly to Mr. Kelsey Fry for his help and encouragement. I desire also to acknowledge most gratefully the contributions of the Dean and Members of the Faculty and Undergraduate Body which have made my stay at this hospital a rare and unexpected treat. I know, now, that had I had the misfortune to have missed this experience I should have been badly cheated.

Living with you and enjoying your daily experiences as in the past six months, I have grown to share your devotion for Guy's. I realize now, too, that whatever intangible quality identifies a man as a "Guy's Man," it is definitely more real and worth while than I ever previously imagined.

After twenty years of dental practice to return to the status of an undergraduate and to have the privilege of addressing fellow undergraduates of Guy's Hospital, is an honour I will always remember and cherish.

Introduction.—I have to present to you, this afternoon, a subject, jaw injuries, that has received great prominence in the past six years. With the outbreak of war, the demand for dentists to splint fractured jaws emerged. Dentistry responded, in the Forces with training centres for instructing Dental Officers in this work, in the Universities through a revival of interest in teaching it to undergraduates and in the literature which brimmed over with countless volumes on every phase and aspect of it, good, bad and indifferent.

The intensiveness of the instructional campaign has left its mark on the profession and we are forced to acknowledge, "The concept of the general practitioner in the dental treatment of jaw injuries." No branch of dentistry offers more spectacular features. At the risk of tiring you with the commonplace I will avoid the colourful aspects of the subject, which have I am sure now been adequately exploited. In consequence, my presentation may relatively be as that of the widow's mite, but the spirit of humility and earnestness in which it is intended, encourages my belief that the vast fund of

learning of this fine institution is accumulated alike from the ploddings of the lesser even as from the brilliance of the greater minds.

As the activities of our jaw injury service ceases and the affairs of it fade into the shadows of an ugly memory, it is timely and fitting that we assess our position. Obscurity and confusion on certain points still persist, and need clarification before our war-time efforts may merit full value.

Incompleteness in studies provides immature conclusions and controversy on the part of authorities is the result. Lacking the unanimity of the specialists, and with his inability to reconcile certain accepted practices in jaw injury management with standard principles of dental practices, the general practitioner, faced with the problem of jaw injury treatment, remains, through doubt, in a position of insecurity and frustration.

While I believe the management of jaw injuries to be a task for those with specialized training and extensive experience, I can see a danger to dentistry in the handing down by one specialist to another of an intellectual armamentarium. The pure dental concept has been too invaluable in the development of this work in recent years to be deprecated.

No doubt exists, I am sure, but that the intensive training in jaw injury treatment, carried out for such large numbers of graduate dentists, is directly responsible for the progressive improvement in masticatory efficiency and oral hygiene that characterized the condition of our hospital discharges. The support and interest now stimulated throughout dentistry should be regarded as an investment to be safeguarded and capitalized upon. Dental reasoning has now established itself as an entity, essential to the successful treatment of jaw injuries, and its value seems to increase in proportion as it conforms to the true concept of routine dentistry.

Specialization.—Some weeks ago an article appeared in a dental publication contributed by a member who styles himself a "Specialist Maxillo-Facial Dental Surgeon." Can you appreciate the implication of his title? Is Maxillo-Facial a suitable name to use for a dental surgeon treating jaw injuries? Where and how does he become a specialist? What are the qualification requirements? Who is responsible to protect the profession against misuse of the term specialist? These are some of the questions involved.

In this connection the 22nd December issue of Guy's *Gazette* published a very interesting article by Hugh Barber that is well worth reading. He laid the responsibility for the standard of the specialities upon the general practitioners, who support them. He said that a lack of interest or indifference towards their responsibilities, in this connection on the part of general practitioners, always influenced a lowering of the standard of the specialists. On these grounds the isolationist manner in which individual dental practices are conducted, presents, as can be readily recognized, attendant risks if specialities are permitted within the profession. I observe the caution with which specialities, so far, have been controlled in this country and I commend you for it. I do believe, however, that it is inevitable in the best interests of dental progress to encourage specialization as we have done in North America. To do this from your present position affords you many advantages which we lacked. You will be able to formulate qualification requirements and obligate certain institutions to safeguard their effectiveness. My opinion is that no graduate should enter a speciality until such time as his success in the general practice of his profession ensures the community that he understands and shares the view point of the average of his colleagues in general practice.

General Knowledge.—To turn again to the general practitioner and the dental treatment of jaw injuries, we admit that opportunity for practical experience will now be greatly limited and will be replaced largely by book learning. This undoubtedly lessens its appeal considerably, though in no wise reduces its importance. I am sure many, like myself, found the necessity of constant references to their libraries for a more intimate knowledge of the oral anatomy, the musculature of mastication, the blood and nerve supplies, as well as the histology and physiology involved in tissue repair. I would like to pass on to you an explanation of the problem of fractures that has improved my understanding of the subject greatly. It is found in the opening paragraph of a book by Watson Jones. He says, "The fracture of bone is the rupture

of living connective tissue and its repair is achieved by cellular growth which characterizes repair in all living tissue. The principles of the treatment of fractures must therefore conform to biological laws and a knowledge of the principles is of greater fundamental importance than any acquaintance with the mechanical details of splints."

It helps me tremendously to understand the behaviour of the damaged jaw tissues when I replace my previous ideas of bone as a solid, friable, dehydrated substance, by this concept of its having the same characteristics as all other connective tissue, capable also of being ruptured as are the soft tissues, rather than fractured as stone or granite as we often consider it. It greatly simplifies the problem of treatment when more tissues fall into the same class. Repair is achieved not by the splints and fixation wires we install but by cellular growth, and to promote this a knowledge of the principles of repair in tissues is of paramount importance. There is great need to emphasize this in dentistry.

Judgment.—I well remember when the U.S. Navy adopted the Stader Splint, the illustrated section of one of our Canadian newspapers was filled with descriptive photography expounding the virtues of the new method of skeletal pin fixation. The appeal was so real that one experienced, after reading it, a shudder that scepticism, which crept in, might be a signal of old-fashionedness, and almost the conviction that to continue the use of any other system was to stamp oneself as out-of-date. However, with experience in the application of this method we discovered that despite its spectacular appeal, like all others, it also had many disadvantages. It has now finally found its place, a very useful though limited one in the armamentarium of the jaw surgeon. The course by which this appliance was appraised is very revealing, and proves the necessity of engaging fundamental principles as a yard stick in the assessment of new ideas, and methods. Dentists engaged in the treatment of jaw injuries, particularly when perplexed by the complexity of the condition, are inclined to abandon at the slightest suggestion, their dental knowledge and accept ready answers put into their mouths, often by less dentally competent associates. Certainly to me the course of skeletal pin fixation, which we have had the opportunity of following in this war from start to finish, is sufficient proof of our need to cling to a dental rock of Gibraltar.

Proportion.—The meticulous care which influences so directly the durability of our restorative work proves a disadvantage in jaw injury treatment. The uninitiated dentist beginning his treatment of jaw injuries wants to do justice to the importance of the occasion and becomes fussier than usual. This generally results in delay and manipulation, both of which are detrimental to speedy recovery and highly undesirable in case management. It appears to me that one of the most valuable things we achieved in our training of Dental Officers in this work, was to assist them to acquire the facility to assess the condition wisely and know how little, not how much, treatment would suffice to make patients safe and comfortable. Early treatment, in advance of infection and manipulation, is generally simple. The use of the uninjured jaw as the best possible splint and the normal relationship of the natural teeth as the infallible guide to the reduction of displacement involves additionally, then, only simple fixation methods to produce exceptional success.

Evolution.—Recent experience has ruled out many previous features, admittedly objectionable, in the treatment of jaw injuries. The acceptance of, fibrous union, the deformed masticatory mechanism, or indifferent oral health, as an inevitable consequence, are now a thing of the past. I am told that in the last war a percentage of each group of jaw fractures were doomed to non-union and even with advances later when union became recognized as essential it was often achieved with complete disregard for the preservation of teeth or masticatory function. I now proclaim that chapter in the annals of jaw injury treatment is closed for ever.

Standard Principles.—To-day, even in gunshot wounds with an extensive loss of tissue, a good standard of conservation and oral hygiene can be maintained both of the teeth and supporting tissues. Much of our success in this connection in my own centre was due to the fact that as a matter of routine we carried out as complete a prophylaxis as was possible of the teeth of each casualty. This refinement in the treatment of jaw injuries unquestionably emphasizes the importance of the concept of the general dental practitioner in this work.

It is unbelievably inconsistent to drudge, as dentists do, day in and day out, in the interests of conservation, if that unremitting diligence and care cannot be extended

to their work on the mouths of the jaw wounded, where teeth are more valuable as a treatment asset than gold or priceless gems.

The need to save teeth in a normal mouth is now universally acknowledged, and we must realize that it becomes infinitely exaggerated in a jaw with a fracture. I would like you to remember this when you set about the removal of a tooth in the line of fracture.

If I asked any group of general practitioners what the indications for the removal of a tooth are, I think I should get a unanimous reply, they could tell me almost specifically the teeth they would retain and the teeth they would remove ; but if I asked them, or even teachers of this subject, " What are the indications for the removal of a tooth in the line of fracture ? " I would receive the reply, " Teeth in the line of fracture must all be removed, except those which are useful in retaining the fragments or holding the fixation appliance." I cannot understand why, if a tooth can be retained if it is useful in holding the fragments or appliance, it cannot be retained under other conditions. I believe, as I have confessed, that the teeth in a fractured jaw all aid in immobilization and are, in consequence, more precious than gold. Their retention is the one thing that from the dental point of view we require most. True, not for very long, but even if one can preserve all the teeth in a fractured jaw for two to three weeks I feel the patient has been carried over the critical period. If healing has proceeded, meanwhile, uneventfully, as it usually does, at the end of three weeks it would be hard to stop the bone from uniting. The loss of the tooth at this stage has no vital importance. Something in this work that is so foreign to the regular demands on the dentist that he fails to realize it, is that in this daily routine work he is involved in making restorations required to last the patient a lifetime. However, in this type of work he is only required to keep the patient comfortable and free from infection for a matter of weeks, or until such time as union has taken place, nature does the work. It is not too late then to make a complete assessment of the dental condition and proceed normally with the required reconstruction. The value of dental reasoning holds in treatment planning, as in the selection of appliances. An up-to-date and thorough nose and throat surgeon will hesitate about doing a throat operation until the teeth are cleaned of debris, tartar and stains, and the septic gums are treated. Other infections in the mouth are likewise treated pre-operatively. If a wisdom tooth is to be removed or some oral surgical operation is to be done it is a matter of routine first to clean the mouth. For fear of damage to the gums, scaling of the teeth is postponed, by some men treating a Vincents infection, till the acute stage is cleared up, yet when it comes to the installation and selection of appliances for intermaxillary fixation, it is amazing how much punishment to the gums they permit by the appliances they have selected for the treatment.

Line of Fracture.—Let us now consider more specifically the teeth in the line of fracture. Progress in conservation is such, in general practice, that the routine and indiscriminate extraction of teeth is no longer countenanced. If pathology is so far advanced that nothing can be done to maintain the vitality of a tooth, one would probably think as a temporary expedient of doing root canal work on it. The application of this rule was made to our jaw injury cases and it became routine never to extract teeth from the line of fracture unless they fell out or had to come out by violation of some dental rule which would make us remove teeth under ordinary circumstances. We dealt with infections in the line of fracture in many instances through root canals. It is very simple even though the jaws are wired together. The buccal wall of the crown is removed to provide access to the pulp, and the canals widely opened, I am happy to say few teeth in the line of fracture were troublesome but, in several cases where they did blow up, the infection responded very favourably to drainage through the root canal. When their purpose was served these teeth were removed. Occasions still persist, however, when one must be very radical, especially in old wounds, but with emphasis on the importance of early treatment these are now rare. I think that the teeth in the line of fracture have been blamed very often in the past for trouble they have never caused, but which were due morelikely to the shortcoming of the fixation appliances, permitting undesirable movement, or failure in the proper application of fixation. These two things stand out in my opinion very much more as offenders in the incidence of infection in a fracture line.

In disposing of the question of teeth in the line of fracture, I must state that the Canadian Centre followed a definite policy of retaining in the line of fracture every tooth that could possibly support itself. Our results were so gratifying that I unhesita-

tingly affirm that I believe it is safer to say retain rather than remove all teeth in the line of fracture.

Impactions in the line of fracture.—The same rule of conservation was applied to impacted teeth in the lines of fracture, and the only cases in this category that presented difficulties were those in which an attempt had been made to remove the impaction. Those left untouched with the fragmented ends of bone, approximated carefully and securely immobilized in this relationship, did very well. It may be claimed that they eventually became cystic and will have to be removed eventually. No evidence has yet proven this point but as a safeguard they could be removed after a year or so if the radiographic findings favour intervention.

Re-establishment of tooth circulation.—The recuperative power of an injured tooth pulp and pulpal artery seems to have received little previous study, and I was amazed to find how favourable it often is in the teeth retained in the line of fracture. If a policy of extracting teeth in the line of fracture is pursued it is obvious that no experience is gained of nature's providence in this connection, and as a consequence nothing is known of the means and extent of the re-establishment of the blood supply to teeth in the injured region.

Radiographic interpretation.—The dental diagnosis of teeth in the lines of fracture has been inevitably slack where the dentist is reticent to obtain intra-oral films of the condition he is studying.

In the past, teeth have been condemned on the strength of an extra-oral X-ray. If we believed extra-oral films adequate for purposes of dental diagnosis, why should we take the trouble to fiddle about with the small dental films and fuss over the difficulties of angulation and their positioning in the mouth. Surely it is easier to standardize an extra than an intra-oral technique.

We have proven that the extra-oral films are not precise enough for our purpose, and it is reasonable therefore to expect that, wherever the highest standards are maintained, they will be supported by evidence from the dental films, except in those very severe cases where this is an impossibility.

Selection of appliances.—A suitable fixation appliance for use in jaw fracture treatment must conform to the dental requirements concerning function and oral hygiene, but as well provide reliable and rigid immobilization. In this connection there are to be found conflicting points of view. One school, fortunately a small one, still supports the idea that movement in the line of fracture favours union. In fact it was very erroneously termed at a meeting I attended early in the war as "the therapeutic application of physiological movement." I could not reconcile my ideas of physiological movement with the mobility of a fracture line. Stimulation, circulation, and movement in joints and muscles should unquestionably be encouraged to the limit, but there seems to be every advantage in rigid immobilization of tissues in a fracture line.

Elastics.—I will discuss here a type of fixation widely used, where rubber elastic band connections are the principal feature. Elastics are recognised as a means of active traction very useful in the reduction of a displaced fracture, but here I discuss their use for inter-maxillary immobilization. I will illustrate my conclusions on this point by an experience I had at a hospital in Salisbury, where a colleague of mine had done his first case of skeletal pin fixation. It seemed alright from without, but when I saw that the patient could open his mouth, I made a criticism concerning the use of this method without a supplementary inter-maxillary scheme of fixation. He replied that an inter-maxillary appliance was also installed and I pointed to the man's open mouth. The explanation came from the patient who said that the kind-hearted nurse had thought to give him a treat by removing his elastics, in order that he might enjoy the comfort of having his meal with his jaws open. How much this act of sympathy set him back in his treatment I do not know, but I could guess. In addition to this disadvantage, that the use of elastics permits through their accessibility to the patient and attendants to tamper with them, they are never at rest and have the tendency to trap food.

Blood supply.—Dentistry has gained much from its work in this war in jaw injuries, but one lesson in my estimation has been an outstanding legacy. This is the importance of a consideration of the blood supply in planning operative procedure. The site and direction of an incision and the prognosis of the case depend so much on how the blood supply to the part is affected. To cut off the blood supply is to encourage pathology.

The problem of dry sockets, post-operative osteitis and osteomyelitis arise from bad circulation. Think of the advances in the treatment of osteomyelitis that have resulted through the acceptance of the procedure of removing the cortical layer of bone and everything superficial to the healthy blood supply of the cancellous structures. Compare the rapid recovery of these cases with the eternal waiting, heretofore, for the casting off of a sequestrum.

Condyles.—Let us now consider some specific conditions. In this connection I would mention the problem of the fractured condyle head. It did not appear very much in the literature until this war, but I think we can account for this by the fact that an increasing use of X-rays has resulted in an increasing number of these conditions being reported. In other words, the diagnosis of them is more common and not that they are actually more prevalent. You will remember that there are signs and symptoms pathognomonic of a fractured condyle head and that a fracture an anterior to the mental foramen region should arouse suspicion of damage to one or other of the condyles. Injury in the anterior portion of the mouth is usually due to a driving force transmitted directly to the condyle heads. I am quite sure that in multiple fractures involving the condyles the fractures occur in the anterior portion of the mouth after the fracture of the condyle head has taken place. Sometimes we even find that the force on the condyle has been so direct that it was driven into the base of the skull.

There are two distinct groups of fractures of the condyles. The first a relatively simple one in which the temporo-mandibular joint has not been disturbed, and the other class where the head of the condyle has been torn from its attachment to, or with, the capsular ligament and is entirely dislocated. The treatment is quite different for each of these classes and it is absolutely essential from the very beginning to classify the fracture and to decide whether or not the joint will ever function again. Where the head has been torn out of the capsule there is no satisfactory means to replace it without the danger of ankylosis. Surgery has been tried but, in that region, because the muscle scars up and causes fixation, it is rather dangerous. The alternative to surgery is a pseudo-arthrosis and the patient with a false joint seems to have no impairment of function.

Do not dismiss these conditions undiagnosed as so many men do, with that resigned unscientific attitude that, as a fractured condyle head, it will either unite or not, and in the latter there will be a false joint, anyway. If there is a good joint, reduce and immobilize it as you would any other fracture. If it is a type of fracture with a dislocated condyle a certain amount of immediate fixation is necessary to avoid an open bite in front or on one side. This immobilization takes place only long enough to ensure that the soft tissues will begin to scar a little and that there will be a pad of scar tissue which will act as the fulcrum of the joint. If the elevator muscles are unrestrained and allowed to pull the fragment up the result will be an open bite in front, shortening the angle at the back. It is best, therefore, in promoting a false joint to ensure a suitable fulcrum, that there should be a week or ten days' fixation of these cases which are then encouraged in unrestrained activity to develop a false joint.

Function.—The matter of ankylosis is something on which a comment may be of interest. I can remember our consulting surgeon was extremely worried about the inter-maxillary immobilization of cases for two or three months. Strangely enough, none of these cases developed more than temporary trismus provided the muscles had not been damaged, but wherever there was injury to the muscles it was a different matter, and we, in collaboration with physiotherapists, were taxed to restore function. I would say, therefore, that the fears that some people have of permanent disability resulting from inter-maxillary fixation, are entirely unfounded unless there has been surgery or laceration to the muscles. When faced with the treatment of trismus or ankylosis, it is a serious problem which involves a considerable amount of attention and force to freeing and breaking down the limiting adhesions.

Occlusion.—The concept of the general practitioner in this work has its crowning application, in the diagnoses of impacted maxillary fractures, based, essentially, on occlusion. As an illustration, take a case I saw here recently. A woman of about 26 with a reasonably complete complement of teeth, but only two teeth in each jaw that met. There was a space between the front teeth with the jaw clenched into which a thumb could be put. If she were to have had a fracture, especially of the maxilla, this is the type of case that could be a great menace. Almost invariably others lacking

your knowledge and experience of occlusion would be sure to say that the teeth should meet all round and that she had an impacted maxillary fracture. Any impacted maxillary fracture can be very difficult to handle, but worst of all is the one of mistaken identity. The inter-locking of fine edges of bone driven across and into one another constitutes the problem and it may take as much force to unlock and disentangle the fragments as was transmitted originally in causing the fracture. Therefore do not expect your fracture cases to have a perfect occlusion because seldom have they got it to start with. To establish a normal occlusion, study carefully the worn spots on the antagonizing teeth, together with evidence of obvious disfunction, and other helpful indications you may discover. Many of your patients have mal-occlusions and should they fracture their jaws, their normal occlusion would be tricky to establish. The correction of a mal-occlusion by an un-united fracture is a frill to the treatment of a fractured jaw that involves numerous and unnecessary difficulties, and is definitely contra-indicated.

Stainless Steel Wire.—Stainless steel has been tried, tested, and used by us in all our wiring throughout the war, and it has in our hands entirely displaced the old favourite, the bronze ligature wire. The stainless steel appliances are relatively free from stretch ; 85 per cent. of all the cases in the Canadian Centre at Basingstoke were wired with it at some stage of their treatment, most of them throughout the whole of the treatment.

Wire Suturing.—A method of reduction and fixation that was very severely frowned upon at the beginning of the war and which has, I think, been restored to favour, is that of bone suturing, or using a wire to bring and hold the fragments of bone together. Fine stainless steel wire threaded through burr holes in the approximating fragment ends at an early stage in cases where there is no other method of controlling fragments is extremely useful and has proven itself by consistent and excellent results. It is known as intra-osseous wiring.

Progress.—Blood transfusion, chemotherapy and the closed circuit method of anæsthetics, have done much to extend our capabilities in surgery as have the use of stainless steel and plastics have made notable contributions to our prosthetic achievements to improve treatment.

Psychology.—Deformity and disfigurement often characterize the condition seen, especially in an early jaw injury. There is a good deal of bleeding and the patient is very apprehensive. Living the experience with your patient, and considering what your concern would be if you were in the same plight, is a wise and kindly relationship to adopt. Re-assure the patient, err on the bright side if anything. You will have no idea what good you will have done the patient.

In this connection there appeared, in 1943, in the journal of Oral Surgery, this article by Sir A. Geddes, entitled "Treating the Patient." "Time and again, when in various parts of the world, I have been ill or injured, or confined to bed, I have been attended by doctors who never found out that I had any medical training ; in fact, they never found out anything about me at all. They were concerned to treat 'The Injury' or 'The Disease' and not me, the patient ; they were in short dealing with a pure abstraction and thinking that they were being very scientific. The more I have seen of life and death, of pain and suffering, the more clearly I have realized that there is never in the real world outside the walls of the Medical School and teaching hospital 'A Disease' to be treated ; there is never 'An Injury' to be dealt with ; there is just a sick child, woman, man to be helped to get well. In short, the real business of clinical medicine is not science. It is, in the case of each sufferer, a personal relationship into which sincerity and medical knowledge are suffused by the physician and trust and some dependence by the patient."

These humanitarian principles pervade all planes and sections of society, and have a special application where the trained and the learned would minister in gentleness and kindliness to weaknesses in mind and body of their fellow creatures.

Some statements I have made may stimulate opposition, and to those they offend I beg forgiveness, but were I to report my experiences otherwise than I have now done I should do an injustice to my unusual opportunities and to the cause of a better standard of dentistry in the treatment of jaw injuries, for which I have worked, in which I believe, and which I will strive constantly to promote.

Physiological Adaptations

A Paper read before the Physiological Society of Guy's Hospital by

D. C. DEUCHAR.

GENTLEMEN,—It has been recognised for some time now, largely as a result of a study of the history of evolution, that adaptability to changing or changed circumstances is essential for the survival of the individual and of the species. It is also recognised that with increasing specialisation the adaptability of any species progressively declines. As Man is often considered to be one of the more highly specialised types at present extant, it is of no little interest to us to investigate what powers of adaptation we retain.

Physiological adaptation is continually occurring within us to maintain the constancy of our internal environment in face of changes in our external environment and our activity from hour to hour. Our nervous systems are constantly active in making those small adjustments in the cardio-vascular and respiratory systems, for example, which are necessary to preserve the proper functional activity of our bodies as a whole. All these are adaptations, but will not be dealt with here.

This paper is more concerned with what happens when the body is subjected to a disturbing influence, or an influence which is a source of embarrassment, not for seconds, minutes or hours, but for weeks, months or even a lifetime, and with what happens when that influence is sufficient to cause profound discomfort, injury or even death if maintained and applied to a degree with which the normal mechanisms of the body cannot immediately deal. For instance, if a non-lethal dose of a toxic drug is administered the body reacts to the drug, and at the same time destroys it or excretes it so that sooner or later it recovers from the dose. If the same dose be regularly repeated as soon as the previous one has ceased acting, the body will be in almost continual discomfort and, possibly, in danger of permanent injury unless some additional protective mechanism is employed or developed. In many cases this occurs, and the subject is said to acquire tolerance to that drug. This type of adaptation is fairly straightforward, although very often the exact mechanism employed is little understood. A very brief consideration of this type of adaptation will illustrate the sort of thing we may expect to find in more strictly physiological adaptations.

The degree of action of any drug depends upon two factors—namely (1) the concentration attained by the drug around the cells on which it acts, and (2) the susceptibility of the cells to the drug. Tolerance can be acquired by adjusting either of these factors. Probably the best known example of tolerance acquired by reduction of the concentration of the drug is that exhibited by the Styrian peasants to arsenic. These people are in the habit of regularly eating inorganic arsenic, which usually acts as a cumulative poison. Their tolerance to the drug is due to changes in the intestinal epithelium, which result in the absorption of the arsenic being greatly reduced. These changes take place quite slowly and the tolerance is built up by taking repeated and gradually increasing doses. If the arsenic eating is stopped the tolerance is not immediately lost—that is, the intestinal epithelium does not at once revert to its original condition. The tolerance of the Styrian peasant is limited to the particular type of arsenious oxide consumed; more soluble forms are fully absorbed and act as cumulative poisons, and tolerance to these forms cannot be acquired.

Reductions of the susceptibility of the cells occurs in the well-known examples of alcohol, morphine and cocaine. In these three drugs the main action is on the central nervous system, and it is the central nervous system which acquires tolerance. Thus the chronic alcoholic can consume a much larger quantity of alcohol without becoming intoxicated than can the person who normally does not drink; but the alcohol consumed by the chronic alcoholic does just as much damage to the remainder of his tissues as it would to anybody else. That the central nervous system becomes adapted to function in an environment containing a quantity of the drug in the case of the alcoholic or morphinomaniac is demonstrated by the result of sudden complete deprivation of the drug. In the case of the alcoholic deprivation may precipitate an attack of delirium tremens, and in the morphinomaniac the result is so profound and disturbing that it is usually necessary to give him a dose of the drug to calm him. As is well known tolerance to alcohol or morphine is not acquired after one drink or one dose respectively; repeated quantities must be taken within a comparatively short time of one another to produce tolerance.

It will be observed that the examples quoted have certain features in common—namely, that adaptation occurs slowly as a result of the continued application of the disturbing influence, that once established it is not immediately lost on ceasing the application and that even when fully established it is strictly limited—that is to say, although the discomfort and harm to the body are substantially reduced the protection is not absolutely complete. These three features will be found in all the examples of adaptation considered here.

In cases where the disturbing influence acting on the body is an essential part of the external environment it may operate over long periods, sufficient to affect several generations. In that connection we are brought back once more to evolution and adaptation. When associated with evolution adaptation most commonly refers to anatomical developments; but anatomical evolution without a sound functional basis is redundant and an early sign of the impending over-specialisation and ornamentation which in the past have led to the extinction of many species. The really important things in evolution are functional adaptations, whether they involve actual anatomical changes or not. It would therefore be of very great interest if any signs of inherited adaptation could be detected among those people who are now living, and whose ancestors have lived for numerous generations in an external environment which requires considerable adaptation for the comfort of the ordinary individual, not usually subject to such an environment.

The three examples which have been selected to illustrate those aspects of adaptation just referred to are those where the diet, climate and oxygen supply are at fault.

In connection with diet it was originally intended to deal with the absence of ketosis in Eskimos living on diets with very low carbohydrate content; unfortunately, on investigation the problem proved to be one of sufficient complexity to warrant a separate paper and, furthermore, from work by Shaffer it appears possible that there is no adaptation involved anyhow.

A more common fault in the diet is a simple insufficiency resulting in undernutrition. Adaptation to undernutrition and to unfavourable climatic conditions is most easily illustrated by changes in basal metabolism. A short digression to say a few preliminary words about basal metabolism is therefore necessary. The value of the basal metabolism, or basal metabolic rate, has been determined in hundreds of normal people, especially in the United States of America, and tables of average normal values for the different groups, according to age and sex, have been compiled by many workers. This work has shown that there is a fairly wide range within normal limits, and basal metabolisms between +10 per cent and —10 per cent. from accepted average normal values are quite likely to be normal. Deviations outside this range do occur, but the percentage occurrence is comparatively small. Although the range amongst different individuals is fairly considerable the variation in the basal metabolism of each individual is quite small over a large number of years, allowing for the gradual trend downwards associated with advancing age. In the many cases of repeated determinations on one individual the majority of the values obtained are within 4 per cent. of the average for that individual, and the extremes of variation rarely exceed 7 or 8 per cent. From these facts it is easy to decide how much significance can be placed upon recorded results. From the wide range of normal values recorded it is obvious that the observation in a single small group of an average deviation from the accepted normal values of less than 10 per cent. is of practically no significance. A deviation of this magnitude can only be of significance when found in large groups or repeatedly in different small groups. On the other hand, maintained variations of upwards of 8 per cent. from original values in individual cases are of definite significance.

To return to the question of undernutrition; it is at once clear that the problem facing the body is that of insufficient food to meet its normal energy requirements. The adaptation it makes is the obvious one—namely, a reduction in its normal energy requirements, by reducing the basal metabolism, and probably by reducing its ordinary activity; though it is, of course, difficult to assess this last point.

Acute undernutrition, or starvation, has been investigated in great detail by many workers. Benedict worked on a native of Malta, aged forty, called Levanzin, who was a professional faster, and he investigated his subject's metabolism during a fast of thirty-one days, during which time Levanzin subsisted on nothing but distilled water. After the commencement of the fast his basal metabolism fell quite rapidly and reached a minimum value on the twenty-first day, when it was reduced by 30 per cent. of the original value per square metre of body surface; after that it rose very slightly and,

when the fast was stopped, it was 26 per cent. less than the original value. An important point to notice here is that the reduction was in the basal metabolism *per square metre of body surface*, and that therefore the reduction in the basal metabolism was not due to a proportionate reduction in the active protoplasmic mass of the subject as the result of the fast, but to a definite change in the metabolic activity of that protoplasmic mass.

The problem of chronic undernutrition which concerns us more here is a far more practical problem, as it occurs on a large scale in some parts of the world, has been a feature of the European diet in two wars and is found in many clinical conditions, such as typhoid fever, diabetes and anorexia nervosa. Magnus-Levy, in 1906, was the first to call attention to the lowered basal metabolism in chronic inanition. He observed it in a patient of his, a nineteen-year-old barber, who was neurasthenic and had lived, or rather existed, for nine months on an exceedingly low diet in an effort to cure himself of constipation. On admission to hospital, little more than a living skeleton, his basal metabolism was —33 per cent., and his diet, which was continued for a day or two for investigation, was found to supply only seven to eight hundred calories a day. He was given abundant food and his metabolism rose to —17 per cent.; then, unfortunately, he developed a fever from tuberculosis, which caused a temporary rise of the metabolism to +9 per cent. On recovery, however, his metabolism was stabilised at +2 per cent—that is to say, quite a normal value. A later investigation was made at the Mayo clinic, in which 117 patients, suffering from anorexia nervosa (or "nervous loss of appetite") and inanition, were all found to have low basal metabolisms between —10 per cent. and —30 per cent.; eleven of them were as low as —30 per cent. to —40 per cent. Master succeeded in lowering the metabolism in patients with coronary thrombosis to between —20 per cent. and —30 per cent. by placing them on a very restricted diet. This reduction, incidentally, is almost as low as that obtained following thyroidectomy, and it has been used therapeutically. More recently Benedict has done an investigation on a series of Y.M.C.A. students in America, who were divided into two groups, of which one was given an adequate measured diet to act as a control, and of which the other was given a reduced diet. The experimental group was given a very inadequate diet for three weeks, when the average loss in weight was 12 per cent. of the original weight, and then placed on a maintenance diet, which worked out at about half of the original diet the students were accustomed to take. It was found that on an average the basal metabolism in this group fell to about —18 per cent. and the pulse-rate was greatly reduced, but that the rectal temperature remained normal. There were signs of a slight falling-off in strength tests, but muscular efficiency was unimpaired. The students, however, were not happy or comfortable and felt the cold more keenly than did the control group; there were also complaints of a lack of "pep" or drive, but otherwise there was no muscular deterioration. The important feature once again was the discrepancy between the loss of weight and of body nitrogen and the reduction of the basal metabolism, indicating that a definite adaptation of metabolism to reduced energy supplies had occurred in the body tissues. It has been concluded that there is a biological adaptation to the reduced energy intake designed to prevent excessive loss of body nitrogen and exhaustion of the reserve of body fat. The continued action of the adaptation after the stimulus for it has been removed has been demonstrated by the delay which occurs before normal metabolism is restored when a more than adequate diet is supplied. A case with a metabolism reduced by 25 per cent. took fourteen days to return to normal with excessive feeding.

The effects of climate on the basal metabolism are intimately connected with the mechanism for temperature regulation. It has been found that with a naked subject the minimum value for the basal metabolism is only obtained within a comparatively short range of temperature of the external environment. If the temperature is reduced an increased heat production to maintain the body temperature is observed, and when the skin temperature is reduced to 19 deg. C. shivering commences and the heat production is raised to between three and four times that of true basal metabolism. This illustrates the mechanism for preventing a cooling of the body, and, of course, it is aided in us by the wearing of clothing, which greatly reduces the threshold temperature below which increased heat production occurs. Because of that cold climates do not have much effect on metabolism, as sufficient clothing is generally worn to render it unnecessary to have an increased heat production.

Hot climates, on the other hand, do have a marked effect, and the reason is not hard to find. The body's usual reaction to an increased external temperature is to

increase its heat loss and not to decrease its heat production. The increased heat loss is nearly all achieved by the evaporation of an increased quantity of sweat and, provided the air is dry so that evaporation readily occurs, this mechanism is quite satisfactory. This was shown by a series of experiments conducted by Benedict and Du Bois, in which various subjects were enclosed in oil-skin bags into which hot dry air was blown. The increase in metabolism, due to the acceleration of metabolic activity produced by any rise of body temperature, was practically negligible till very high temperatures were used. Even when the air was blown in at 94 deg. C., so that it was almost unbearably hot, the increase in the metabolism was only about 5–7 per cent. Unfortunately, in those places where the climate is hottest, such as the Tropics, the humidity is also very often high. Under these conditions the sweat induced by the heat does not evaporate satisfactorily, the body temperature commences to rise and produces a hyperthermal rise in metabolism, which aggravates the condition; sweating is increased still more and becomes very exhausting. When the atmosphere is humid exhaustion, prostration and even death are caused by temperatures—31.5 deg. C. with 66 per cent. humidity in New York in August, 1905, for example—which do not even produce discomfort if the air is dry. When exposed to such hot, damp climates the body makes the easiest adaptation available; the heat production is reduced by a lowering of the basal metabolism. Investigation has shown that residence in the hot climate of the southern States of the U.S.A. leads to reduction of the basal metabolism varying from 6 to 16 per cent., and a group of white people living in Queensland, Australia, with a summer temperature of 85 deg. F. and winter temperature of 60 deg. F. (compare London's summer temperature of 64 deg. F.) gave an average value of —20 per cent. Martin measured his own basal metabolism whilst on a trip from England to Australia and noted that it began to fall within a few days of encountering heat, but took five days to reach the minimum value. The maximum difference which he recorded between the cool and hot periods was 12 per cent.

Having now considered the effect of climate and moderate undernutrition on the basal metabolism we are now in a position to assess the effect of these factors on native populations who have been subjected to them for many generations. The evidence available here has been mainly derived from studies on racial characteristics in basal metabolism. Briefly summarised, the results which have been obtained are as follows:—Groups of native Australians gave average values between —12 per cent. and —30 per cent., and one group compared with a control group of whites living under similar conditions gave an average value of —16 per cent, whilst the whites were only —7 per cent; a group of Malays in Java gave an average value of —10 per cent, compared with —7 per cent for a group of whites; various groups of natives in India gave values between —7 per cent and —17 per cent; in Madras a group of natives gave a value of —17 per cent compared with whites resident there of —10 per cent. In Syria natives were —13 per cent and Europeans only —6 per cent. The most striking fact here is that all these native groups have metabolisms lower than the whites with which they were compared. It would be nice to argue that this was due to inherited adaptation, resulting from the influence of the adverse condition of climate and nutrition on many generations of the native population. Unfortunately it has not yet been established fully that the depressed metabolism is inborn and not due to the climatic and dietary factors acting from birth. Benedict has investigated the metabolism of the Chinese, who in China are found to have basal metabolisms lower than that of whites in America, and has attempted to demonstrate the presence of this lower basal rate in eighteen Chinese girls born and bred in America. Although the results he has obtained support the belief that these lower rates are inherited, as he himself points out, the differences from the accepted standards that he found in a small group of girls, only about 6 per cent, are not sufficiently large to be of any significance. Even if it were definitely established that these racial characteristics are inherited, it would by no means be certain that they were wholly due to the influence of climate and diet as it has been shown that groups of Maya Indians living on the hot Yucatan peninsula, where white people have reduced basal values, give average basal metabolisms of up to 8 per cent. above the accepted standards. The whole question of these racial characteristics in metabolism is one of great interest and one which clearly presents a vast opportunity for full and detailed research.

(To be concluded.)

The References will appear at the end of the second part of this article, which will be published in the next issue of the "Gazette."

Correspondence

Surgery in the Provinces

SIR,—As an obscure provincial surgeon I feel that your editorial remarks in the *Gazette* of 17th August should not be allowed to pass without protest. One must assume some foundation for the pathetic story of the devoted but inexperienced house surgeon doing his best under impossible conditions but, surely, such circumstances are not common even in the provinces.

Prior to the 1914 war I held resident posts in a number of provincial hospitals, and in none did the surgeons leave major operations to inexperienced residents, nor did they allow "nature to take her own course." It has been my good fortune to be on the honorary staff of a large provincial hospital for nearly thirty-years. I may claim to be a busy surgeon but not, I trust, an unscrupulous one. The latter individual I have yet to meet: according to Cronin the species is not confined to the provinces. Neither my colleagues nor I have been in the habit of leaving inexperienced house surgeons to cope with serious emergencies, whatever the financial position of the patient or the hour of his admission to hospital.

Space will not permit me to comment on the "very clear distinction between a London and a provincial hospital," but the distinction appears to be more obvious to the Editor than to the writer of this letter.

Yours faithfully,

C. C. HOLMAN.

21, Billing Road, Northampton.

Clubs' Union

SIR,—At a recent meeting of the Clubs' Union Council it was decided that more publicity should be accorded the activities of the Club and the decisions of the Council.

The Honorary Secretary was empowered to send, from time to time, a brief note to the Editors of the *Gazette* and of *Pulse* so that their readers might become acquainted with information about the Clubs' work. I should be most grateful if you would publish this note now.

I am, Sir,

Yours faithfully,

RAYMOND HINDE,
Hon. Secretary, Clubs' Union.

Guy's Hospital, S.E.1.

Letters

SIR,—Would it not be possible for the letters in the Colonnade racks to be arranged for the benefit of the illiterates who have never been taught the alphabet backwards. ?

Yours, etc.,

M. E. N. SMITH.

Guy's Hospital, S.E.1.

Hospital Information, etc.

Change of Address

J. R. Audy, Lt.-Col. R.A.M.C., Dept. of Entomology, London School of Hygiene and Tropical Medicine, W.C.1.

C. F. Hawkins, M.D., M.R.C.P., The Queen Elizabeth Hospital, Birmingham, and 133, Stanway Road, Shirley, Birmingham.

Martin G. Thorne, Lt. R.A.M.C., Camp Reception Station, 25 Garrison, British Forces in France.

D. Paget-Davis, M.R.C.S., L.R.C.P., The Close, Challis Lane, Braintree.

P. V. Reading, M.S., 31, Reddons Road, Beckenham, Kent. (Tel.: Syd. 5320.)

Marriages

WASS—BLACKIE.—On August 20th, 1946, at Brighton, Samuel H. Wass, M.S., to June Mary V. Blackie.

EDS. {R.H.N.L. R.T.H.

GUY'S HOSPITAL GAZETTE

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PASSIM

PROPINQUITY, save for the South African and the Welshman, and family ties are two reasons for a man coming to Guy's. A third, the most important, is the hospital's reputation for emphasising the practical aspect of the doctor's work. Father, who has to pay the fees, has been lead to believe that his little genius will be given the opportunity while still a student to sew up cuts, let out pus or tap the bladder, as well as all those other hundred-and-one crafts of the seamstress and plumber with which our calling abounds. Guy's used to offer these chances and expected them to be taken. If they are no longer available, what remains ? From the student's point of view, little except a great reputation which, as something to live on, is as useful as a nerve tonic.

Prior to the war, the appointment of senior dresser was one of great dignity. It followed the first taste of real responsibility as an extern, it entailed a not inconsiderable onus in the Front Surgery, it involved the greater part of assisting the surgeons in the theatre, the daily dressings following the operations, a measure of minor surgery and the adventure of perhaps an appendicectomy or the repair of a rupture vouchsafed by a generous and trusting chief. In addition, there was the privilege of playing the host and paying the bill at the dressers' suppers at which small talk to the registrar and games of poker with the house-surgeon could be indulged. Fagging the ward-clerks and tipping the porters were further perquisites of this unique three months.

How sad that this old glory has gone. The senior dresser of to-day is what Mr. Cook once called a superannuated ward-clerk. In the surgery he is entrusted with only the pettiest procedures ; in the wards, for him to do a dressing is an event, the prize of his own persistance or the sister's patronising permission ; in the theatre he may or may not be asked to scrub-up and if he is, it is to stand for long hours with his germ-free hands clasped before him as if in prayer for the reward of holding a retractor or, crown of crowns, a malleable light. The theatre staff, satisfied that the operation can progress quite well without him, use the dresser as their whipping-boy, though they may be disposed to exchange a civil word so long as no one higher in the hierarchy is there to claim the benefit of their attentions and so long as an unfortunate ward-clerk is standing by to receive the chastisement essential for bearing in upon him his lowly estate.

The causes of this change of status of the senior dresser are two. First, a reduction in the number of beds with yet as many students as in pre-war days. And second, the multiplication of registrars and housemen who, having had as war-time clinical experience only the keeping of ward-room wine-accounts in His Majesty's destroyers, mean to undertake themselves every possible operation, major and minor. The crumbs left for the luckless dresser are meagre, indeed. It is, of course, true that having had little to do he becomes inclined to do little ; and often when asked to change a dressing or watch the house-surgeon make a lumbar puncture he prefers to excuse himself by attendance at one of the many lectures now provided him at all hours of the day.

We have considered only one student appointment, but in the main it applies to all. It may be deduced that the teaching to-day is not that of which Guy's used to boast, and is that less an attraction to influence a man who might well have been advised to go elsewhere.

On another page, we publish a letter from the Acting Chaplain. With a national shortage of nurses of something like twenty thousand, his charge is a grave one. He will be adjudged a brave man to have inferred anything against the black-habited mothers superior of the Matron's office, and he will probably pay the penalty of his heresy and be martyred by them. Now although there is no smoke without

a fire, Mr. McClaughrey, before he burns at the stake, might have made the cause more worthy by getting his facts right. He has presented half-truths.

If we read him aright his thesis is this. That because of a lack of recreation, the nurses in training lose their cheerfulness of disposition, with which they have presumably begun it. He says that the majority come to Guy's full of enthusiasm and interest; that many have a real desire to nurse and care for the sick, but that after a time they lose heart and their work becomes wearisome. Later he quotes a conversation with such a one who confides to him that her one desire is to finish with the whole business as soon as possible and get away from the hospital. We do not in any way doubt the veracity of this last heart-rending tale. But there are two conclusions to be drawn. That was one nurse. There may have been others and even were there a dozen more, Mr. McClaughrey is still guilty of arguing from the particular to the general. And that is invalid. Again, this disappointment after two and a-half years might have been the occasional boredom which is suffered by anyone in any walk of life. We ourselves have shared this nurse's feeling on many occasions, and so perhaps has the Acting Chaplain when, from time to time, he wearies of the pursuit of righteousness.

To impute loss of cheerfulness as being anything but uncommon among the nurses can be only the outcome of careless observation. Anyone who daily comes into contact with Guy's nurses must be impressed at once by their cheerfulness; and this in spite of the lives they lead. The "Block System" to which Mr. McClaughrey alludes is, we understand, to begin in the early part of November and will, be it hoped, do something to minimise the lot of those who are bold enough to take up nursing. As for recreation, the facts are these. Within the hospital and nurses' home are reading rooms, lounges, a squash court and a swimming bath. At Honor Oak Park the Clubs' Union allows the nurses use of the tennis courts and a pitch; though what they play on the last we are not quite certain. And as for what Mr. McClaughrey is pleased to call cultural and intellectual recreation, these are best organised not by busy-body lovers of mankind but by those whose tastes bring them together of their own volition. It is not unlikely that many nurses prefer to use their off-time by leaving the hospital and visiting the art-galleries, concert-halls, theatres and historic churches with which London abounds in preference to second-hand gramophone recitals or third-rate nativity plays of local origin.

We hold that the letter in question is one of half-truths and have stated the half we believe to be unjustified. But all of us know how great are the demands made upon the nurse; the hectoring, harrying and badgering that she receives daily from doctor, patient and sister; the long hours; the often tedious duties; the required servility; and the dulness of mind which the life engenders. We also have it from many nurses themselves that their life here is much less irksome than that prescribed in other hospitals. Yet we have a suspicion that when the mothers superior are criticised on when complaints reach them they resent it. That like the tortoise they withdraw within their shell until the intruder is hushed; then like him re-appear and with his speed and stately poise tread on in progress. Thus does the national nursing shortage become reduced from twenty thousand to nineteen thousand and five hundred.

Believing that the subject raised by the Acting Chaplain is of great importance in the hospital life, we hope that some, particularly the angels themselves, will jump in where Mr. McClaughrey has not feared to tread, and write to us.

We remind our tom-cats that their collars must be affixed and their licenses obtained from the Superintendent's office by Monday, September 16th. A plea of hysterectomy will not reprieve their wives and daughters from the gas-chamber.

Our thanks are due to the present externs for their work in restoring the Externs Room. The neo-Grinling Gibbons carving and the priceless murals will once more delight future generations of pelvic artists. It is hoped that a two-day exhibition may be arranged and we shall be pleased to give this notice in our columns. Will anyone who knows of the whereabouts of any of the treasures kindly communicate with Mr. J. C. Holman at Guy's Hospital.

We are pleased to announce that the substantial sum of fifty pounds, proceeds from the Theatre Club presentation of "French without Tears," has been handed to the Appeals Secretary.

THE Biennial Dinner is to be held soon. We hope to publish the date of this splendid news later. The Innominate Club announce their first post-war dinner elsewhere. After so many years of separation, these dinners will mean a great deal to old Guy's men.

WITH great regret we bid farewell to Mr. Rodney Long who has resigned the editorship. We had not the privilege of being his colleague for more than two or three weeks, but in that period we learned how much time and thought he had given the *Gazette*. In thanking Mr. Long for his services and asking him to accept our good wishes we welcome as assistant editor, Mr. D. H. Forsdick, who will be remembered as one of those who undertook the gruesome work at Belsen after the relief.

An Unusual Uterine Developmental Defect

Presented by M. CALLER and N. P. DAVIS

(with the permission of Dr. Katz, Resident Obstetrician, Brighton Municipal Hospital).

THE congenital abnormalities of the uterus are well-known. The condition reported here is of sufficient rarity to merit description.

Mrs. S., aged 24 years, a nullipara, was admitted to the Brighton Municipal Hospital on July 21st, 1946, complaining of continuous bleeding per vaginam. She had been married three months. A further complaint of dyspareunia was elicited, pain being felt in the right iliac fossa throughout intercourse.

Menstruation commenced at the age of 18 years. The periods, with a scanty loss, lasted 5 days and occurred regularly every 28 days. The period prior to admission was of 7 days duration. The first 6 hours of menstruation were associated with the severe pain characteristic of spasmodic dysmenorrhœa.

A diagnosis of "Missed Abortion" was made, and it was decided to proceed with a dilatation and curettage. When the cervix was brought into view, it was seen to be duplex. The mid-line was occupied by a band of vaginal tissue, which separated the two cervices. On the left side, the development of the cervix appeared to be normal, but the right cervix was deficient medially. Each cervix possessed a patent canal, and these were shown to be in communication with each other, via the uterine cavity. During curettage through the left cervix, retained products of conception were voided through the right cervix. Furthermore, a bent probe was easily passed into one cervix and out of the other. Apart from being acutely retroverted, no deformity of the uterus could be demonstrated. There was no evidence of either a uterine or a vaginal septum.

On July 31st, a wedge resection of the right cervix was performed, thus removing a potential danger should the patient ever be in labour. The defect was closed with interrupted catgut sutures, and the vaginal vault reconstructed with a continuous catgut suture.

A ventral suspension of the uterus was indicated to correct the retroversion, and this afforded an opportunity of inspecting the uterus directly. It was of the type described as "Uterus Cordiformis" (*vide* "Combined Textbook of Obstetrics and Gynæcology," revised by Munro Kerr, 1944, page 103), there being a shallow median depression in the fundus uteri. The body felt thicker on the left side. A cyst of the Hydatid of Morgagni was enucleated on this side. The round ligaments were poorly developed, and ventral fixation was performed.

A review of the literature gives evidence that Uterus Bicornis Unicollis is not excessively rare; Uterus Bicornis Bicollis is of lesser incidence, and is usually associated with uterine and vaginal septa. Of the condition described above, the writers were able to identify only three similar cases which have been reported since 1894. A case described in the Italian Archives of Gynæcology of 1903–4 bears a marked resemblance to the present condition. This abnormality naturally lends itself to the name of "UTERUS CORDIFORMIS BICOLLIS."

The writers are indebted to Dr. E. Katz, M.D. (Berlin), for his kind permission to report on this patient.

REFERENCES.

(1) Centralblatt f. Gynak., Leipzig, 1894. Uterus bicollis unicorpus.
(2) Archiv. Ital. di Ginec., Napoli, 1903–4, vi., 261–263.
(3) Takenguchi, Japan, 1907. A case of a uterus with one body and two cervices.

Physiological Adaptations

A Paper read before the Physiological Society of Guy's Hospital by

D. C. DEUCHAR.

(*Concluded.*)

Lastly, we come to the problem of mountain sickness and the mechanism by which the body becomes acclimatised to oxygen lack at high altitudes. This has been deliberately left till the last, as it presents by far the best picture of adaptation and because it has been fully investigated by Barcroft, who went from Cambridge with a party of other workers to study this problem at first hand in the Andean Mountains.

Mountain sickness is the name which has been given to the distressing condition which afflicts all those who ascend great heights in a comparatively short time ; it has now been shown conclusively that it is due to insufficient oxygen at the low atmospheric pressures which are encountered above 10,000 feet and that the most distressing symptoms result from a deficient supply to the lower centres of the brain. That this condition is a distressing one and one which calls for an effort by the body to adapt itself to the low partial pressure of oxygen is best indicated by the following description by Dr. Redfield :—" In the Andes the disability which most men suffer on coming into the rarified air is termed 'seroche.' Its severity is sufficient to give it in connection with the mining industry a certain economic importance. While a few men were met who had never felt it and many who had suffered but mildly, a very large number are so greatly affected as to be completely incapacitated for several days. In at least one authentic instance the 'seroche' of a normal healthy person has been terminated by death.

" Each case is an individual story and up to the present no one has been able to predict who will and who will not be affected. A description of cases of two degrees of severity will serve to picture the chief features of the disorder.

" Making the ascent by train, one lightly touched by 'seroche,' experiences his first symptoms at an altitude of 10,000 feet or more. Subjectively, lassitude, then headache, usually frontal, growing in severity, and perhaps nausea are felt. One feels cold, particularly in the extremities, the pulse quickens, respiration becomes deeper and more frequent, the face is pallid, lips and nails are cyanotic. On descending from the summit to Oroya at 12,000 feet, though a marked improvement is felt one finds himself reduced to a helpless condition of weakness which renders the least muscular effort irksome and productive of shortness of breath, dizziness and palpitation. The night's sleep is restless and, on waking, one feels much as one does on venturing on to his feet after recovering from an acute infection. In two or three days one's strength returns, the colour improves somewhat and all but the more severe forms of exertion may be undertaken without distress. The majority are less fortunate than this. During the ascent the symptoms are qualitatively the same, but frequently more severe, and nausea gives way to vomiting. The night's sleep fails to bring relief ; severe headache, gastro-intestinal instability and weakness continue for several days ; the body temperature may be supranormal (102 deg. F. by rectum), and at times one is aware of palpitation. Cyanosis is marked. After three or four days in bed relief comes, and in a week normal activity may be resumed."

The means employed by the body to adapt itself, and thereby relieve the symptoms just described are several, and involve many adjustments in the body, especially of the respiratory and vascular systems. One of the first to become apparent is an increase in total ventilation, which has the effect of reducing the alveolar carbon dioxide with a corresponding increase in the partial pressure of oxygen in the alveolus, as the composition of the alveolar air more nearly approaches that of the atmosphere. The partial pressure of carbon dioxide may be reduced by about 10 mm., which at high altitudes may equal about 20 per cent. of the total oxygen tension in the alveolar air. By this means, then, a 20 per cent. improvement can be achieved, but the reduction of the alveolar carbon dioxide leads to a reduction of carbon dioxide in the blood, which in turn results in increased alkalinity. If no other change took place this rise in the *p*H of the blood would produce a diminution of pulmonary ventilation ; that is avoided by excretion of bicarbonate by the kidney, so that a considerable percentage of the bicarbonate in the blood disappears and the *p*H of the blood is maintained at its normal value.

There is also a rise in the quantity of hæmoglobin in each cubic centimetre of the blood, and later in the body as a whole. The exact mechanism of the early change is rather obscure, and the alteration seems to be due to a diminution of the oxygen pressure in the blood and not to a reduction of the oxygen content. This is indicated by the fact that the increase of hæmoglobin may be such that the oxygen content may rise above the normal despite the reduced oxygen tension. It was thought by some that the immediate hæmoglobin increase was due to a reduction of blood volume, but it seems doubtful. More likely it results from use of the cells normally stored in the spleen, as it has been shown that most of the hæmoglobin in the spleen is outside the general circulation normally, and that in anoxæmic conditions there is a considerable contraction of the spleen. By this contraction the spleen may add 100 cubic centimetres of corpuscles to the circulation, which is equivalent to 5 per cent. of the total volume of the circulation. Later the principal factor in the maintenance of the higher hæmoglobin value is without doubt an increased production in the bone marrow, as the total increase of hæmoglobin is great beyond anything available from storage organs, and large numbers of reticulated, or young, red cells appear in the blood.

The object of the increase in hæmoglobin is not immediately obvious. Increase in the amount of oxygen as such is no advantage, as normally blood contains three times as much as is needed. Even at high altitudes there is more than enough oxygen far beyond necessity in the blood, but the capillary oxygen tension is too low, so that insufficient diffuses into the tissues. That the increased oxygen content is an advantage is explained as follows : If the tissue oxygen requirements remain constant, an increased oxygen content of the blood will lead to a decrease in the percentage unsaturation in the venous blood, which will mean a greater oxygen tension in venous blood. It so happens that the oxygen tension in capillary blood is much closer to the venous than to the arterial value, so that increased oxygen tension in venous blood leads to increased oxygen tension in capillary blood, which is the effect desired.

A more subtle effect is obtained by a change in the *p*H of the red corpuscles which Barcroft detected by special means. It will be recalled that the *p*H of the plamsa is maintained at its normal value ; but the red cell contents of the acclimatised individual are more alkaline than usual. The effect of this increased *p*H is to shift the dissociation curve of the hæmoglobin so that it absorbs oxygen much more readily in the lung. This is of value, especially during exercise at high altitudes, when the blood might not have time to reach equilibrium owing to low oxygen pressure in the alveolus. If that occurred it would mean that the oxygen tension in the arterial blood would be less than the limiting value in the alveolus, which in turn would result in a lowered capillary oxygen tension. The change in the curve enables equilibrium to be more easily reached, but it also renders the giving up of oxygen to the tissues more difficult. This is a disadvantage of course ; but the disadvantage to tissues if blood can get the oxygen and gives it up less readily is less than that if the blood cannot get the oxygen so well in the first place.

There are changes also in the cardio-vascular system affecting the volume of blood circulating per unit time, which are difficult to analyse simply, and which certainly impose a greater load on the heart at high altitudes. The pulse under basal conditions is unchanged, so is the ordinary resting pulse until very high altitudes are reached, but it quickens more rapidly on exercise than at lower altitudes. The general effect of these changes seems to be similar to that of increasing the hæmoglobin.

It is interesting to note that the burden of the symptoms of mountain sickness are due to the effect of oxygen lack on the medulla. Acclimitisation could be aided directly by increasing the blood supply to the brain through readjustments in vaso-motor tone. Unfortunately, whether or not this does occur has not yet been investigated, but it does seem possible in the light of more recent work.

Whether or not oxygen secretion by the alveolar epithelium, as postulated by Haldane, contributes to this acclimatisation is too controversial a matter to deal with in the short time available ; but Barcroft could obtain no evidence to indicate that it did.

Finally, let me quote Barcroft on this acclimatisation :—" Redistribution of disadvantage is the real essence of acclimatisation. The acclimatised man is not the man who has attained to bodily and mental powers as great in Cerro de Pasco as he would have in Cambridge. Such a man does not exist. All dwellers at high altitudes are persons of impaired physical and mental powers. The acclimatised man is he who is least impaired, or, in other words, he who has made least demand upon his reserves. At rest he will appear like the dweller on the plain, but exercise will always bring him to a standstill sooner at the higher altitude.

"The most acclimatised man is he whose system can distribute the extra strain most evenly over the whole organism so that no one part will give way before any other.

"The readjustment of the load between the blood and the tissues is shown by the movement of the dissociation curve, but it is only an incident in the whole phenomenon of acclimatisation, for the whole process is one which ramifies over the entire range of the body's functions. If one sits down to answer the question whether or not anything remains absolutely unaltered at high altitudes, it is not an easy matter to find one such function."

Even after acclimatisation had been achieved the members of Barcroft's expedition were afflicted by some symptoms. Cyanosis was constantly present in all members, although it was much less than was observed when they first ascended the mountains; even the native population were all cyanotic, and in them and the visitors the blueness was increased with exercise. They all found that prolonged physical exertion was not possible, and in all members the effect on the mental processes was insidious, but eventually quite apparent; prolonged concentration gave evidence of lowered control. In many the appetite was irregular and capricious, sleep was almost uniformly disturbed and not of long duration, and loss of weight was a common feature.

Brief mention has just been made of the native population, and it is interesting to note the degree of adaptation they have attained. These natives constitute an indigenous population of the Andean Pampa, known locally as Cholos; they live in very ancient and primitive societies, and seem to have achieved a considerable degree of adaptation to the low oxygen pressure. They are capable of considerable feats of physical strength and endurance quite beyond those of the Europeans resident there, including the engineers at the mines. Thus compare a typical job of work for these natives, which consisted of carrying a 100-lb. load up a flight of rough steps 250 feet high and 600 feet long from a mine after which they were breathless, having taken frequent pauses on the way up, with the physical ability of the members of the expedition. They found that a walk similar in gradient and length to that in London from the Houses of Parliament to the National Gallery could be accomplished with a fine swinging gait and with a semblance of respiratory comfort—so long as they were not burdened with an overcoat! When it rained and trench coats were donned their progress was markedly slower, and some of them stopped occasionally to take a long-drawn breath. Incidentally, the natives declared that their physical ability was due to the cocaine to which they were addicted, but whether that was so is by no means certain. Insofar as Barcroft could investigate them they displayed the same adaptations as the visitors, only to a marked degree, and, in addition, possessed certain interesting physical features. They were all short in stature, had straight black hair, high cheek-bones, aquiline noses and yellow skins. But the interesting features were their hands and chests. Their fingers were clubbed often to a considerable degree, a sign associated with circulatory and pulmonary disorders involving oxygen want. The shape and size of their chests was even more significant; they were large and deep, out of proportion to their stature and definitely barrel-shaped. Relative to height the Cholo chest is the same height as ours, but its breadth is quite 10 per cent. greater. Unfortunately, the problem again still remains for future workers to determine whether the difference in the Cholo chest from ours is one which may be acquired by children whose bones are not set or even by adults, or whether, on the other hand, it is congenital.

In conclusion, we can observe that we do possess some ability to adapt ourselves to considerable changes in our external environment, but that in all cases our ability is strictly limited. On the other hand, no concrete and definite evidence seems to have yet been produced to show that Man anywhere has undergone evolutionary adaptation.

REFERENCES.

Tolerance to Drugs. "Applied Pharmacology," by A. J. Clark.
Ketosis and Eskimos. Shaffer. *Journ. Biol. Chem.* 47, 433 & 491, 1921.
Waugh *et al.* *Amer. J. Dis. Child.* 1938, 57, 1343.
"Basal Metabolism in Health and Disease," by E. F. Du Bois.
All Aspects of Basal Metabolism. "Basal Metabolism in Health and Disease," by E. F. Du Bois.
Undernutrition and Starvation. "Science and Nutrition," by G. Lusk.
"Human Physiology," by L. Luciani.
Basal Metabolism in Chinese. Benedict & Meyer. *Chinese Jour. Phys.* 1933, 7, 45.
Climate and Temperature Regulation. "Science and Nutrition," by G. Lusk.
Mountain Sickness Second volume. "Respiratory Functions of the Blood," by Barcroft

Lesser Known Guy's Notables

RALPH MOIGNARD WINGENT—1878-1913

By GEORGE A. R. WINSTON.
(Wills Librarian)

RALPH WINGENT was a talented student, who, from 1907 until his death in 1913, brightened the pages of the Guy's Hospital Gazette with his unsurpassed sketches and caricatures, and raised its literary level by his historical articles on places of local interest.

He was born on 14th February, 1878, at Moat House, Rochester, Kent, and educated at Sir Joseph Williamson's School in that city.

From his earliest boyhood he amused himself at drawing (with his left hand) and though his education in art and classics was not extensive he continued both pursuits after leaving school, making himself a competent and original draughtsman in black and white and a very fair Latinist.

At school he was an athlete of all-round excellence and in one year became the school sports champion after a strenuous series of contests in the sprint, long-distance and jumping events. It was only when a severe attack of rheumatic fever had left him with a legacy of aortic disease that he settled down into the quiet manner by which most of his contemporaries at Guy's knew him.

In October, 1897, at the age of nineteen, he entered Guy's and in due course successfully passed the first examination of the Conjoint Board. This was as far as he got in his attempts to secure this diploma. Constant poor health probably led him to believe that the hard mental and physical work, necessary to the fulfilment of the profession he had chosen, was beyond him. Nevertheless, he persevered with his medical studies, passing the primary examination of the London Society of Apothecaries in Physiology in 1901 and in Anatomy in 1903. He then proceeded to take the final parts, but only passed in Midwifery in 1903 and Surgery in 1911. He never qualified, but his heart was in other work, principally antiquarian research.

Soon after he came to Guy's he became intensely interested in the foundation and history of the Hospital, and in the early history of Southwark and London Bridge, both of which he pursued with great enthusiasm. He spent many hours in the British Museum and other places and searched for records of the district from every available source until he became an authority on the topography of this part of London. If he could have been planted down in Elizabethan London he would no doubt have found his way about without asking.

In 1912 he began to publish a series of articles on "London Bridge and the Borough in the Eighteenth Century," which were collected together and published in a volume entitled "The Borough and the Borough Hospitals." At the time of his death in December, 1913, he was engaged on a second series entitled, "The Resurrectionists," being an account of the old and gruesome trade of "body-snatching." During his last illness his one anxiety was to complete the final article for the *Gazette* but his energies had been so severely taxed that he never finished it.

Besides his articles, which form a lasting memorial of value and interest to Guy's men and others, he created a series of topical pictures of Thomas Guy and the Hospital which will endure for all time as small masterpieces of topical events. A number of these pictures—cartoons and programme designs—were issued in portfolio form in March, 1913, and had a good sale at two shillings and sixpence each.

As an artist Wingent had a most distinctive style. There could be no doubting his drawings even if they were not signed. For example, he often portrayed the student or youth, immaculately dressed, with the old-fashioned high collar, bow tie and neatly parted hair. During his period the *Gazette* was rich in talent, as it received contributions from the famous Stanley Cock, whose drawings were mainly caricatures and differed greatly from those of Wingent. Curiously, Wingent never signed his contributions in the same way, usually using one of four: R.M.W., R.W., Ralph Wingent, or R. M. Wingent.

His love for the Hospital and its founder can be traced in the many drawings appearing under his signature. No less than seven published in the *Gazette* are con-

tributions portraying Thomas Guy as the kindest and most charming of men. Without exaggeration he brought Thomas Guy to life.

One of the best of Wingent's drawings was his acknowledgment to Phil May's famous "Punch" cartoon, "Come Inside," depicting Guy looking over a wall, with the hospital in the background, beckoning to a student outside. His last picture, "A Tour of Inspection, October 1724," shows the Hospital nearing completion and Guy walking round the platforms of the scaffolding examining the beautiful building which was to bear his name.

Wingent paid tribute to another famous Guy's man, John Keats, who, like himself, was destined not to practice the profession for which he had studied and to which he had devoted so much time. In many respects their medical careers were similar; both suffered the agony of cruel disease; both had interests outside their profession, Keats as a poet, Wingent as an artist and antiquarian; both studied for the diploma of the Society of Apothecaries; and both died at an early age.

Wingent's imaginative art is typified in a delightful drawing of Keats sitting in the lecture theatre, published in the *Gazette* in 1908. The words "John Keats born October 29th 1795, died February 23rd 1821" are surrounded with the familiar wreath of laurels. The names of famous Guy's men of Keats' period are carved on the desks and include those of A. Cooper, R. Sawyer and B. Allen. The drawing is accompanied by a quotation from Isabella:

> Ah! wherefore all this wormy Circumstance?
> Why linger at the yawning tomb so long?
> O for the gentleness of old Romance,
> The simple plaining of a Minstrel's song!

Another excellent drawing, "Episode for a Guy's Pageant," was suggested by a passage in Wilks and Bettany's History of Guy's:

> "Sir Astley's fame was European so that distinguished foreign surgeons never failed to visit him at the hospital. We read of Dupuytren going round the wards with him. When he took leave he saluted the worthy baronet on each cheek. The manner in which Sir Astley submitted to the ceremony afforded no small amusement to the pupils standing round."

In this sentence Wingent saw an opportunity of illustrating the embarassment on Sir Astley Cooper's face and the laughter of the onlookers standing behind the railings of the colonnade.

For many years Wingent had been examining various articles of antiquarian interest which had been found in different parts of the Hospital, and it was his ambition that they should be collected into a small museum for the benefit of Guy's men and women and thus ensuring the preservation and protection of the exhibits themselves. Several times he discussed the scheme at meetings of the *Gazette* Committee and at last, in June, 1912, the first Committee of the "Gazette Museum of Guy's Antiquities" was formed which included Dr. Herbert French, Dr. John Ryle and Mr. Ralph Wingent, the latter being elected honorary curator. Thus Wingent left one more memorial behind him before his death at the early age of 35.

The foundation of this Museum was almost entirely due to Wingent and it was known to everybody as "Wingent's Museum." The old bone room between the Wills Library and the Gordon Museum was selected and a small collection of exhibits of interest to all lovers of Guy's Hospital was adequately displayed in the showcases. The room housing the exhibits was demolished in 1936 to enable the Wills Library to be extended to provide further accommodation. The relics were placed in two large show-cases in the Library close to the original site. There thay can be found to-day.

It is rather surprising that with his reticent character he made such a host of friends, but the fact was that this shyness arose from his dislike of talking about himself and his work. Even his own people were unaware of his first series of articles for the *Gazette*. Once his reserve was pierced he could talk well, and with mature judgment on art and literature. He liked better to give than to receive, and it was a fitting tribute to head his obituary notice, "Dare Quam Accipere." He was always ready to do a sketch for the Christmas Play or any other subject. In spite of bad health he was wonderfully cheerful, never complaining about his illness or the uncertainty of his career. He had no personal vanities and was only happy when doing things for others.

Of the loss of his career it is not necessary to speak, but it could hardly be expected that a man whose energy was fast ebbing away could stand the strain of the profession

to which he had devoted himself. His record will live, but in a sphere other than that of his profession.

In 1914, soon after Wingent's death, an appeal was made by Dr. F. Seymour Price and Dr. Corry Mann for a fund to establish some permanent memorial to his memory, and it was suggested that this should be placed in the Museum of Antiquities.

Those who had known him since he first entered as a student highly valued his unselfish friendship, and the standard if fellowship which he set among Hospital men, all of whom admired his brave patience through eleven years of physical infirmity. The memorial was intended to leave the coming generation of Guy's men a record of brave and patient endeavour which distinguished the life of a man who never spoke ill of those around him and who knew not the petty jealousies which only too often hamper and shame the work of others.

There was an immediate response to the fund and Dr. Price and Dr. Mann announced that it was intended to purchase a grandfather clock to be placed in the Wills Library, but owing to the disorganisation of the clock-making trade due to the outbreak of war in 1914, it was not possible to obtain delivery. It would have been easy to devote the sum collected to some other useful purpose, such as the purchase of books for the Library or the foundation of prizes for the Medical and Dental Schools, but as the war proceeded, and many of Wingent's friends were killed at the front, the Trustees felt more strongly than ever that the plan arranged, with their approval, should be carried through, even if it meant postponement until after the war.

There the matter rested until 1920 when at length it was possible to obtain an oak grandfather clock of 18th Century workmanship with a handsome dial that harmonised beautifully with the decorations of the Wills Library, and which now rests practically on the site of the old Museum of Antiquities where Wingent spent many of his happiest days. The clock bears brass plates on two sides with the inscription, IN MEMORIAM, RALPH WINGENT, ARTIST. STUDENT AT GUY'S HOSPITAL 1897–1913—a fitting Memorial to the artist and antiquarian.

Such was Ralph Moignard Wingent, in many respects a man of genius. How far he would have gone in his profession one cannot guess, but that he had the natural qualities that go to the making of a physician there was no doubt.

Correspondence

Dragon's Teeth Drawn

SIR,—Your otherwise admirable Passim in the last issue of the *Gazette* contains one factual error, one too pessimistic speculation, and one *jeu d'esprit* which has flicked me on the raw !

Martha Ward provided twenty-six beds in 1939, not forty as you say twice in one paragraph. It now gives accommodation for the whole of the staff of the Counting House, the Governors' Committee Room, and the Hospital branch of the National Provincial Bank. In any institution a certain amount of space must be set aside for the administrative offices, and this one ward replaces the whole of the east wing of the Front Quadrangle. It must be remembered, too, that at the time when it was decided to utilise Martha Ward for this purpose, the east side of Guy's House had been pronounced irreparable by expert opinion.

Speculations as to the probable date of completion of the new Guy's have more than academic interest, and those who are best placed to judge regard ten years as the outside figure. That may not appear to be an optimistic forecast, but it is very much less pessimistic and, at the same time, more authoritative than the estimates to which you refer.

Lastly, " the breath of that monstrous belching dragon " flicks me on a very raw place ! More than one Superintendent and more than one Clerk of Works has tried to find the remedy and we are still trying. The fact that the nuisance continues is no indication of the efforts that have been and are being made to combat it. The contributing causative factors are many and various, and anyone may be responsible on any particular occasion. Difficulties of coal supply, quality as well as quantity, difficulties of labour, mechanical and human, difficulties associated with the very variable demand, all come into the picture, at different times and in varying degrees.

STUDENT TYPES

I. EX-SERVICE

But that the " dragon " should continue to behave in such a deplorably vulgar manner is not accepted as inevitable, and at the present time his behaviour is forming a special subject of investigation for one of the leading consulting engineers in London.

As it is difficult for anyone not actively concerned with the work of restoration to appreciate how much has been accomplished during the past twelve months, and as some ingenuous souls appear to believe that nothing has in fact been carried through, I propose to ask you to publish in your next issue a statement covering these activities.

Yours, etc.,

T. B. JOHNSTON,
Superintendent.

Guy's Hospital, S.E.1.
September 9th, 1946.

Pastoral Opinion

SIR,—As one who is not a member of either the medical or nursing profession, but has had an opportunity of observing at close quarters the life and work of Guy's Hospital for almost three years, may I be permitted to suggest what appears to me to be one of the greatest needs of the nursing staff, namely, *recreation*.

It is a sad feature of the life of nurses in training that after a short time they lose that cheerfulness of disposition which has always been considered a *sine qua non* of good nursing.

In my work as Chaplain I meet nurses when they first come to the Preliminary Training School. The majority come full of enthusiasm and interest; many have a real desire to nurse and to care for the sick. But after a time they lose heart, and their work becomes wearisome.

Recently I asked a nurse who, two and a-half years ago was keen and enthusiastic, what she intended doing when she finished her training. She did not know, and her one desire was " to be finished with the whole business as soon as possible—anything," she said, " to get away from hospital ! "

The two main reasons for this not uncommon change of attitude towards nursing seem to be overwork and lack of recreation. The " Block System," and the 48-hour week, when it comes, should help to rectify the first. Let us hope that when the " Block System " is instituted in Guy's facilities will be made for nurses' sports and games nearer to Guy's than Honor Oak Park, and fuller provision made for cultural and intellectual recreation.

All work and no play spoils many a good nurse.

Yours, etc.,

V. T. McCLAUGHRY.

Surgery In the Provinces

SIR,—I was very pleased to see Mr. Holman, of Northampton, take up the cudgels on behalf of the Provincial Surgeon in reply to your Editorial. " The very sharp distinction between a London and a Provincial Hospital," which you claim to exist is surely a geographical one only. Hospitals of all grades will be found to exist in each category.

In actual fact, the circumstances in which the Provincial Surgeon is placed require him to act with the greatest circumspection. Whereas at Guy's or other large hospitals, the patient is almost always an entire stranger, in smaller hospitals such anonymity is not the rule. More often than not the employer, the vicar or some other well-intentioned person rings up the hospital (and often the Surgeon himself) within a few hours of the operation to enquire after the condition of their protégé. The name of the Honorary Surgeon in charge of the case will certainly be known, and any short-comings in treatment will quickly bring their repercussions.

The Provincial Surgeon is doubtless as fond of his bed as anyone else. For that reason he does his best to train his Housemen so that the latter can tackle emergencies such as you picture to their mutual advantage and without undue risk to the patient.

Nor does the other aspect of your picture, that of the tired and over-worked House Surgeon, pale from lack of sleep, ring true. All Surgeons have been Housemen in

their day. If your picture were correct a "National Union of Housemen" would long ago have been formed to secure shorter hours and more pay. Perhaps we shall have it before long!

It is not quite clear, Sir, what moral you wished drawn from your paragraph. If it was to point out the advantages of a House job at a teaching hospital over a job in the Provinces, you will find few to contradict you. The critical atmosphere and progressive methods of the teaching hospital are sadly missed by us all in the Provinces. In only one respect does the Provincial House-surgeon have an advantage. He will probably have under his care cases (*e.g.*, genito-urinary, gynæcological or E.N.T.) which at Guy's would be segregated in special departments. Granted the same degree of "receptivity" he may gain during a single year experience which it would take his London colleague several consecutive appointments to acquire.

I am, Sir,

Yours faithfully,

B. G. SCHOLEFIELD.

SIR,—The self-styled "obscure Provincial surgeon" has assumed the mantle of innocence on behalf of his colleagues, but how uneasily he wears it; and to what purpose? After reading Mr. Holman's letter I paid you the rare compliment, Mr. Editor, of re-reading your "Passim" and in it I could find nothing to which either Mr. Holman or anyone else could genuinely take exception. What is it that Mr. Holman is quibbling at? Why does he protest?

For one thing he has missed, or ignored, the whole essence of the "Passim," which seemed to me to be concerned with the lot of the house surgeon outside London and was not, on your own admission, an attack on Provincial hospitals and surgeons. If he had read in your words a tendency for the modern houseman to be unprepared to face the tasks demanded of him, I might have sympathised with Mr. Holman, I might even have been impressed, though I should not for one moment have agreed with him.

But no, Mr. Holman grasps what is irrelevant, and then what does he do? He does precisely what he should not have done and he is lost. He mentions Dr. Cronin. He says he has yet to meet an unscrupulous surgeon, but "according to Cronin the species is not confined to the Provinces." This extraordinary statement is a contradiction of his own implications. It admits that the species exists and, further, that it exists both in the Provinces and in London. Even if Mr. Holman were trying to persuade us, as he possibly was, that London alone housed the unscrupulous surgeons, this "counter-implication" (as it might be termed) bears no stamp of truth, for Mr. Holman's own words lend no support to it. It is conviction that he lacks, or is it just plain logic?

You, Sir, speak of "the very clear distinction between a London and a Provincial hospital" and Mr. Holman declares that this distinction—although space will not permit him to comment on it—is more obvious to you than to himself. How right Mr. Holman is—about the space! One feels that he could wallow in several issues of the *Gazette* without being one whit nearer to proving his point.

I am, Sir,

Yours, etc.,

URQUHART DUCHESNE.

"Passim"

SIR,—As one who was considering the formation of a Conservative Association at Guy's, I feel I must make some reply to your surprisingly acrimonious Passim of August 31st. In this rather premature Editorial you have not only misconstrued the aims of such an association, should it be formed, but have also misinterpreted present-day politics.

In this country our government, both central and local, is based on the party system, and if anybody is to make any contribution to politics, it must be through the medium of one of the major parties.

The times when the doctor could ignore politics are unfortunately passed. Quite apart from the major issue of State Medicine, the doctor is abruptly brought into

politics through Local Government. Both town and county councils are run on party lines, and both are spheres in which doctors should be pre-eminently interested. It is becoming more and more apparent what a vital affect living conditions have upon the prevalence of certain diseases, yet it is with these very conditions that local councils are primarily concerned. It is surely highly desirable that doctors should be represented on these councils ? If that is to be so, they must stand as the representative of some party, and the aims of our Association would be to discuss this relationship between medicine and politics, and not to discover potential M.P.'s, as you rather ludicrously infer.

It is a pity you marred the latter part of your Passim by sinking to the level of childish invective. That you would attack the B.M.A. was almost inevitable, but why give only one side of the picture ? After all the B.M.A., for all its failings, is the only organisation that has made any serious attempt to present the profession's case to the Government.

As for the " crabbed, hunted, stunted creature," clamouring to get on all available committees, he appears to me to savour too strongly of editorial journalese to be taken seriously.

Yours, etc.,

R. A. KEABLE-ELLIOT.

Persecution at the Final Fellowship Class I.

Mr. A—s. : If you give that as your opinion at the examination in November, you will be asked to leave the examination hall and sent into Queen Square to graze upon the grass.

Mr. B—k : Doctor, doctor, I cast a pearl before you and you call it a pea.

Mr. W—s : If you are advising operation upon this case in the light of Euthanasia, I entirely agree with you.

Ed.—Our readers are asked to devote two minutes daily in silent contemplation of the sufferings inflicted upon their contempories at the hands of these taskmasters.

Hospital Information, etc.

Notices

THE INNOMINATE CLUB.

The Post-War Reunion Dinner will be held at the Trocadero Restaurant at 7 p.m. on Friday, 18th October, 1946. Price of Dinner, excluding wines, 17*s.* 6*d.* (in advance).

All desirous of attending, please communicate with the Hon. Secretary.

G. T. HANKEY,
79, Harley Street,
London, W.1.

Tel. : Welbeck 7476.

ANNUAL DENTAL DANCE.

The Committee of the Dental Society is pleased to announce that the Annual Dental Dance will be held at Grosvenor House, Park Lane, on Friday, 15th November, 1946.

It is hoped that this second Dental Dance since the war will see the occasion restored to its former position as one of the great social events of the year at Guy's.

A special welcome is extended to those Guy's men who, recently released from the Services, have had little opportunity to meet old acquaintances.

The tickets, priced one guinea, include full Buffet and Refreshments. Dancing will be to the music of Ted Heath and his band.

NOTICE.

There will be a meeting of the Clubs' Union Council at 4.30 p.m., on October 3rd, to confirm the following alteration of the rules. The place of meeting will be announced later.

The affairs of the Union shall be managed by a Council of twenty-five. Of these six shall be members of the Hospital and School Staff, to be elected annually at a School Council ; seven shall be members of the Hospital and School Junior Staff, to be elected annually by a meeting of the Junior Staff Committee ; and twelve representatives of the Students, to be elected annually in October in the following manner :—

(i) Two to be appointed by the Committee of the Students' Club.

(ii) The Hon. Secretary of the Rugby Football Club.

(iii) The Hon. Secretary of the Students' Union.

(iv) Four to be elected from among the Hon. Secretaries of the other Athletic Clubs. The Secretary of the Rugby Football Club shall convene a meeting of Secretaries of the Athletic Clubs who shall form an electoral body.

(v) The Hon. Secretary of the Dental Society.

(vi) Three to be elected from among the Hon. Secretaries of the other Non-Athletic

Clubs. The Secretary of the Dental Society shall convene a meeting of Secretaries of Non-Athletic Clubs who shall form an electoral body.

RAYMOND HINDE,
Hon. Sec. Clubs' Union Council.

Pass List

UNIVERSITY OF LONDON.

SPECIAL FIRST EXAMINATION FOR MEDICAL DEGREES.

(For Internal Students.)

July, 1946.

T. G. L. Bellis	E. J. Masters
R. J. O. Catlin	J. M. Medlock
J. W. Comper	E. M. Newton
M. J. Craft	P. M. J. O'Brien
J. J. Dickens	D. J. Oliffe
G. Dixon	J. Palmer
G. H. Fisch	P. L. Pelmear
D. W. G. Forrest	H. F. Pile
J. C. Gazet	W. J. Pryn
N. B. Gillison	S. H. Richards
J. C. Jelleyman	D. J. Stoker
T. G. R. Jones	T. G. Thomas
A. M. Kingon	W. W. Thompson
C. McEwen	W. M. E. Tweed
H. McNally	R. A. J. Webb
R. Marx	R. S. Wells

The following External Candidates have completed exemption from First Medical:—

D. M. Devane	G. C. Saint
W. R. Edwards	J. Scorey
P. W. Ruggles	

The following Higher School Candidates have qualified for exemption from First Medical:—

J. W. Goodfellow	J. A. M. Martin
G. C. A. Holden	I. M. Sharpe
P. J. Holloway	

UNIVERSITY OF LONDON.

SPECIAL SECOND EXAMINATION FOR MEDICAL DEGREES.

(For Internal Students.)

July, 1946.

J. E. Breese	G. L. Jones
D. G. Chalmers	J. A. B. Jones
O. F. Conran	D. M. Lewis
J. D. Crowle-Smith	J. A. Loeb
J. B. Davies	C. R. Lynn
S. S. Epstein	E. W. Melia
A. T. T. Forrester	G. F. M. Pierce
M. C. Gilbert	J. K. Price
R. Handy	A. E. Richardson
K. R. Heber	G. W. Scott
M. C. H. Jackson	L. Tann

UNIVERSITY OF LONDON.
B.Sc. SPECIAL EXAMINATION IN PHYSIOLOGY.

July, 1946.

First Class Honours.

D. J. Anderson, B.D.S.

Change of Address

Ft.-Lieut. P. D. Bryant, R.A.F., 190691, R.A.F. Hospital, Mingaladon, Burma.

Dr. J. Rosenberg, P.O. Firgrove, Vredenhof, South Africa.

Papers by Guy's Men

Bradley, W. H., and Others. The Middlesex smallpox outbreak. *Brit. Med. J.*, 1946, ii, 194.

Woodhead, Barbara. The psychological aspect of allergic skin reaction in childhood. *Arch. Dis. Childh.*, 1946, **21**, 98.

Pringle, K. E. Variations in response. *Dental Rec.*, 1946, **66**, 187.

Southwell, N. Inhaled penicillin in bronchial infections. *Lancet*, 1946, ii, 225.

Biden-Steele, K., and Another. Poisoning by D.D.T. Emulsion. *Ibid.*, 235.

Brockington, Fraser. Premature births in Warwickshire, 1945. *Pub. Health*, 1945-6, **59**, 166.

Harvey, Warren. The application to civilian practice of some dental lessons of the last war. 3, R.A.F. *Brit. Dent. J.*, 1946, **81**, 111.

Lyon, D. J. A condition simulating a dental abscess. *Ibid.*, 126.

Bennett, T. I. Hypertension and its Treatment. *Nursing Mirror*, 1946, **83**, 343.

Reading, Philip. Some uses of Thrombin in the surgery of the ear, nose and throat. *Brit. Med. J.*, 1946, ii, 295.

Forbes, John R. Myth and Mumpsimus. *Lancet*, 1946, ii, 293.

Appointments

The title of Reader in Pathology in the University of London has been conferred on S. J. De Navasquez, M.D., in respect of a post held by him at Guy's Hospital Medical School.

R. W. B. Ellis, M.D., has been appointed to the Edward Clark chair of child health at the University of Edinburgh.

Clarkson, Patrick, M.B.E., M.B., F.R.C.S., Plastic Surgeon, Ministry of Health. At Basingstoke Plastic and Jaw Centre (Part-time).

C. W. Harrison, L.D.S., has been appointed Hon. Dental Surgeon to King Edward VII Hospital, Windsor.

The Services

AWARDS.

Efficiency Decoration of the Territorial Army.

Major J. N. Martin, R.A.M.C.

Mentioned in Dispatches.

In recognition of gallant and distinguished services in Malaya in 1942.

Major (Temp.) H. M. S. G. Beadwell, M.B.E., R.A.M.C.

In recognition of gallant and distinguished services while a Prisoner of War:—

Captain F. B. Lake, R.A.M.C.

Births

IMRAY.—On 24th August, 1946, to Peggy (née Lee, S.R.N.), wife of Dr. Michael Imray of Bowden House, Market Harborough.—a daughter.

EDS. { R.T.H. D.H.F.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

THE beginning of the new university year is fast approaching, and Guy's awaits to welcome some more students through its portals. This year they will not be all new faces for, with the large proportion of returning servicemen included in the list of new entries, some old acquaintances of the hospital will be resuming their studies. All these ex-Guy's men will be older and wiser since the days they used to sit in the park or read in the library, and all will have had experiences that only a war can bring, many will have memories they would rather forget. What will they think of their old hospital and, conversely, what will their old hospital think of them ?

They will see the scars that five and a half years of fighting have produced, and perhaps they will find it difficult to realise that some of their old and favourite haunts, like the "Spit" and the "Ship and Shovel," are now dust or, at most, a heap of débris. The hollow echo of their steps as they climb the wooden staircase in Hunt's House will remind them, no doubt, how lucky the medical block has been during the years of their absence.

Perhaps they will find an alteration in the type of person at Guy's, although it will be difficult for them to make, in that particular, the necessary allowance for the change in character that a few years of active service can produce. They may regard many of their new colleagues as young and immature—little more than schoolboys, clamouring after glasses of milk and ice-cream in preference to the traditional pot of beer. Perhaps when they have tasted some of the beer, they will understand !

Will they, in their turn, be regarded as odd, or will the present population agree that they have just grown up differently ? While not anticipating anything so dramatic as the rumble of a Bren gun carrier in the courtyard or a clatter of spurs in the colonnade, the present students may expect to see a fair proportion of "wing-span" moustaches or even to hear a smattering of Hindustani as some of the new men adjourn to *Tiffin* or call for another *chotah peg* in the George.

Yet, for all the differences that both sides may appreciate, it will be of nothing but an amusing consequence for there will grow, as always, that warm spirit of comradeship that exists wherever Guy's men are gathered together. Some will refer to the "dining-room," some to the "mess," but both the new and the old will settle down to work for their common goal—to become a good doctor.

WE are pleased to publish in this issue an article by Dr. Hugh Barber, Consulting Physician to the Derbyshire Royal Infirmary and an ex-Guy's medical registrar. In his article Dr. Barber mentions that rather ethereal quality, so essential to the good doctor, the "bedside manner." To state what constitutes a good professional manner at the bedside is beyond the scope of the Editorial pen, but all of us have some idea of certain of its features.

In these days when test-tube-laboratory science is making such strides it is very easy to find out much about a patient's condition without getting to know the patient himself. Whilst all these aids for investigation that science provides are indeed invaluable, the attendant physician must never regard his patient as a mere bed-ridden chemical formula whose equilibrium has been disturbed by a few ill-placed ions or, if he does look upon him as such, must certainly never let him know. Patients are

and always will be human beings, and the gaining of their confidence, friendship, and respect are as important to-day, when the atom has been split, as it was when even molecules were never recognised.

Students entering the wards are taught thoroughly to take a "history." To be successful in this, the patient's confidence must be obtained otherwise he will tend to tell half-truths and become bored with his doctor—a feeling which may often be reciprocated. Now, different people have different ways of approaching the patient. Some, and this is reserved mainly for tall honararies and short registrars, assume a position of partial suspension over the bed, by grasping that rope and handle contraption supplied primarily, it is believed, for a particular need of the patient. Although this sounds a very ungainly attitude these particular persons really look surprisingly comfortable and often quite dignified. When the ward-clerk tries it, either he cannot reach the rope, or it breaks, or he is swept off his feet to land either on the patient, or on the far side of the bed. Such antics at the bedside are, of course, unseemly.

Again, there is a subtle move made by some whereby the right or left (rarely both) foot is insinuated between the mattress and the bed-spring. This, for the uninitiated, can be a highly fatal move, bringing upon the unfortunate not only an uncontrollable attack of vertigo but also the wrath of the ward sister whose nearest and dearest concern is the laundry list. It must be remembered that whilst qualified doctors *never* dirty counterpanes, the unqualified *always* do.

The same may be said about the much favoured and highly successful method of "sitting on the bed." Again it must be realised that the body-weight of the qualified is distributed in such a manner that sheets and counterpanes are *never* creased, even when a semi-recumbent position has been adopted. The more lowly frame, on the other hand, is such a mass of rugged contours and bony promontories that the effect of its mere partial weight on linen is sufficient to throw the whole of the nursing staff into instant convulsions.

The method of addressing the patient as "my dear," or that delightfully homely title "Dad," while sounding natural and pleasant when uttered by senior lips, seems ill-phrased by the junior and may, on occasions, bring a blush to his youthful cheeks.

Thus it would seem that while the student may mould his professional attitude to that of his favourite physician or surgeon, he must beware of acquiring too soon those little habits which are permitted only of the privileged. He should, for the time being, be content with the more unelaborate and indefinite qualities, such as cheerfulness and sympathy, to gain for him the reputation amongst his patients of being, at any rate, a good friend.

We should like to request any of our readers who have interesting cases to report on, to do so in the pages of the *Gazette*. Such articles are always popular and afford interest to a large number of our readers both at home and away from the hospital.

We extend our sympathy to the Beckenham Cricket Club for losing all their wickets, in a recent match, to the bowling of E. W. Graham who would only allow them sixty-seven runs.

We can assure them that such a feat has previously been unknown in the annals of Guy's cricket.

The Preliminary Training School for Guy's nurses is to move to the 46-acre estate Holmesdale, near Redhill, Surrey. An advance party of sisters and maids are already there to make some of the necessary preparations. The move is a temporary one until some of the new quarters at Guy's are built.

We congratulate Mr. W. R. Spurrell on his recent appointment of Professor of Physiology to the University of London, and Dr. S. J. de Navasquez on his appointment of Reader in Pathology.

Pathognomy at the Bedside

By HUGH BARBER, M.D., F.R.C.P.
Consulting Physician, Derbyshire Royal Infirmary,
Medical Registrar, Guy's Hospital, 1903–1905.

For there are mystically in our faces certain Characters which carry in them the motto of our Souls, wherein he that cannot read A.B.C. may read our natures.
—*Religio Medici*, Sir Thomas Browne.

IT would be a good question to set in a final examination :—Describe what may be learned by study of the patient's countenance. Most students would mention the Hippocratic facies, the risus sardonicus, circumoral pallor, a malar flush—all these and more—not forgetting cyanosis or dilating alæ nasi. One that would be worthy of honours should add that many of the most important conclusions may be drawn from changes in facial expression, which are there to read but in themselves are indescribable.

The ward-clerk sees some of them. Sister may see what others miss. The house-physician sees much more than when he was an undergraduate, and the physician most of all—if he is the right type of physician. Now a shrewd ward-clerk, looking on, may see much more expression in the patient's face when the physician arrives. There is only one personality concerned with Babinski's sign or a rash (excepting, of course, a blush) but there are two personalities, in the ordinary way, to any facial expressions. The simplest illustration may be taken from a man with a slight degree of facial paralysis, in which we all know that an involuntary smile gives better evidence than attempts at voluntary movement. A doctor friend of mine once told me that he found it difficult to achieve a smiling patient. It is the easiest thing in the world, if you remember that mirth is infectious, and find some simple means of smiling with him.

A good medical face at the bedside, however, draws out from a patient innumerable expressions, of all varieties and delicacy of shade. It may be compared to a wireless receiving set. It picks up messages in direct proportion to its sensitivity. And, moreover, when it is obviously working, more messages are transmitted. I once went out in consultation to see a well-known woman, whom I had never met. She called for her horn-rimmed glasses and gave me an honest stare. When I said : "Do I pass the test ?" she responded : "You'll do." This is not so trivial as it might seem. For once in a way that it is expressed in words, there are many more occasions when it can be assessed by the patient's facial expression. A child, on all occasions, and an adult, who may be seriously ill, should have the opportunity of taking a good look at a doctor who is a stranger. In hospital one may come straight to the point, in some cases, by asking a young woman why she is looking at Sister, whom she can see any day in the week, and not at oneself.

We know an anxious expression ; we can recognize fear. We may get a hint that something is withheld, or by contrast a look of complete confidence. The common emotions of suffering, surprise or disappointment, can be recognized in the face. We can see, perhaps, that there is some question on the tip of the tongue. There is little to gain by verbal descriptions. It may be all commonplace enough, but the physician who can send his messages in return by the same channels, or sometimes by word of mouth, will get better results than one who uses conventional gestures and platitudes in the belief that he has a bedside manner.

The eighteenth century enthusiasts for their science of physiognomy liked to use high phrases, such as to call the eye, "the window of the soul." It is true that the use of the ophthalmoscope is not the only means of looking beyond the lens. It is also true that in some cases of hysteria, or if we may use the term state of nervous exhaustion, the patient may pull down the blinds of the window by closing the eyelids.

Often enough, however, there is something short of this ; in which a lack of mutual understanding is the reason why no messages are passing. When I was a small boy I heard a cold and rather pompous grown-up laying down the law, that no dog could face the human eye for long. When we were relieved of his presence, I tried out the experiment with my own dog, and found that we could look at each other almost indefinitely. I wondered what was wrong ; but I think now it was the grown-up. He would have cut a poor figure as a doctor. It may be a bad sign when someone

does not look us in the eye. It was the pawnbroker in Stevenson's story of *Markheim*, who said that sometimes a customer with something to sell could not look him in the eye; adding, "Well, he has to pay for that." For those of us, however, who meet people down on their luck, or tired and out of health, it behoves us to reflect that one who does not look us in the eye might do this quite easily with someone of greater understanding than ourselves.

By what right does one use this word Pathognomy? I got it from my great-grandfather who was a Member of the College of Surgeons, London, and who became, eventually, lecturer on Elocution at Harvard University. He edited a book on physiognomy, and it appears that pathognomy signified the study of the movable and moving parts of the face; or as they called it the physiognomy of the passions. We read much about the standard types—The Sanguine, The Choleric, The Melancholic and The Phlegmatic, but there is no mention of the finer shades. It is far removed from anything which my great-grandfather can have used at the bedside of his patients, before he gave up medicine for elocution—perhaps what he saw there may have been indescribable in words.

In the standard book on physiognomy of the eighteenth century by the German, Lavater, we find the word pathognomy in the index; and turning up the reference may read: "Pathognomy has to combat the arts of dissimulation; physiognomy has not." From this, I suppose, we may draw two conclusions. First, that the word was understood so well that no definition was required; and second, that Lavater was more interested in anatomy and measurements of the features than in facial expression.

It may be true that "pathognomy has to combat the arts of dissimulation"; but the messages, when understood, have less possibility of being misleading than have words. Joseph Addison, in the "Spectator," wrote: "a man's speech is much more easily disguised than his countenance." Dickens points out that there may be no messages, when he describes Ralph Nickleby's clerk: "The expression of a man's face is commonly a help to his thoughts, or a glossary on his speech; but the countenance of Newman Noggs, in his ordinary moods, was a problem which no stretch of ingenuity could solve."

Physiognomy had been studied by Hippocrates, Aristotle and Galen. The layman had views—just as he has to-day. Joseph Addison could write in the "*Spectator*": "For my part I am so apt to frame a notion of every man's humour or circumstances by his looks, that I have sometimes employed myself from Charing Cross to the Royal Exchange in drawing the characters of those who have passed by me." He was thinking probably, in the main, of facial expressions. Lavater, who concerned himself chiefly with measurements and the more fixed features, gives one hundred rules; but they are not very convincing, although there may be some wisdom in what he has to say about the forehead, the nose and the chin.

Mr. Shandy took the nose very seriously. You remember how he was prostrated with grief, when he heard that Doctor Slop had broken the bridge of his first-born's nose with ill-applied forceps. To remedy this permanent handicap in life, he decided his child must be christened by so high-sounding a name as Trismegistus. Although, with a whole nose, he would have let him enter the battle of life as plain George or Edward.

To digress into this philosophy of nomenclature is not without interest for the psychologist. Stevenson has a word to say about those who come "top-heavy from the font." As for example—William Shakespeare Brown. Now from time to time, a good family doctor may get a side-line on the parents' psychology, by coming across a child with a name that is a trifle heavy. In all seriousness, it would be disastrous to exercise any levity, but the doctor may have got a hint, which will guide him towards a little correction. If Augustus Lancelot Jones, aged ten years, is given out leg-before-wicket, he is more likely to dispute the umpire's decision than if he had been christened John William.

In the nineteenth century physiognomy split along two lines. The anatomical measurements degenerated into Phrenology. It is surprising what serious consideration this so-called science received; as may be seen by study of the early numbers of the *Lancet*. It flourished across the Atlantic. The Boston Phrenological Society held its first meeting in 1832, on which occasion my great-grandfather was invited to give the inaugural address. As befits the effort of an elocutionist, it has a fine flow of sonorous words, but he skims lightly over the bumps, telling the Bostonians to have an open mind in their studies, and not to expect too much.

I do not know when phrenology died; but I have seen it as a side-show, beside the seaside; and the "professor," at half-a-crown a time, was well worth the money to the small boys looking on. One of the first patients I attended in private was a pawnbroker, who had one of those models on his mantelpiece, with a pot-head marked out in little green squares on the surface, with love, envy, ambition, and all the rest of them printed. My patient left a considerable fortune, but was very reticient about his dealings in phrenology.

That branch which the eighteenth century physiognomists called pathognomy progressed into the study of the expressions. It was in 1806 that Sir Charles Bell described the facial muscles in his *Essay on the Anatomy of the Expressions*. He attempted to point out the arrangements by which the influence of the mind is propagated to the muscular movements which usually accompany the various emotions and passions. Duchenne in 1862, with the aid of photography and the use of electrical stimulation confirmed and elaborated this work. Finally, we have Darwin's book on *The Expression of the Emotions in Man and Animals*. He was concerned with such questions, as the reason why we turned up our noses in contemptuous moods. Not, you make me tired; but I do not like the smell of you. He admits that there are many well recognised expressions of the countenance that are difficult to describe. He concluded that our expressions, through evolution, are inherited and have become in-born instincts.

It was Edgar Allan Poe who could see the other side of this. There is that schoolboy, in his story of *The Purloined Letter*, who said, "when I wish to find out how wise, or how stupid, or how good or how wicked is anyone, or what are his thoughts at the moment, I fashion the expression of my face, as accurately as possible, in accordance with the expression of his, and then wait to see what thoughts or sentiments arise in my mind or heart, as if to match or correspond with the expression." I think this is rather an attractive idea. There might be something in it. There are difficulties, however, in its practical application outside the monkey-house in the Zoo.

From facial expression we come naturally to telephone conversations; because what are spoken words unsupported by a look of any sort? If one sits, by chance, in the office of someone doing big business, it does seem extraordinary that it can be carried through over the telephone. How can he tell that the man at the other end is speaking the truth? How can he tell whether the other man is satisfied, or whether he is weakening in a bargain? Perhaps a future generation, with television, will solve this difficilty. But when a doctor goes into practice, he soon learns that there are some things which can only be settled face to face. Suppose there is a patient seriously ill in a private house. There is every justification for some anxiety on the part of the relatives. In my opinion, the doctor is free to ring up the house to obtain a report on his patient, but on the other hand, if a relative in the house rings up the doctor, it is almost certain that he should make the opportunity for a special visit, reasonably soon, to allay some anxiety, which may grow and reach his patient. The doctor cannot tell whether his opinion has given satisfaction unless he has seen the facial expression of the enquirer. I do not mean that he must take seriously every foolish question over the telephone; but in an art so difficult as medicine, he should refuse to give opinions on serious matters without seeing the questioner.

Every doctor knows that facial expression at the bedside is all important during a physical examination. What a difference between one surgeon, with delicate hands, gently insinuating his fingers around what is called Macburney's point, watching his patient's facial expression the while; and another surgeon prodding his fingers into the right iliac fossa with the comment: "Does that hurt?" The one gets the true evidence, although the other may get the appendix.

Now about this science of Physiognomy. It seems improbable that we shall try to revive it. Yet, I suppose, we do judge character by looking at the countenance. There are some anatomical features that impress. For example, we have the Roman nose, the receding chin, the broad forehead. When Tennyson wrote of "narrow foreheads, ignorant of our glorious gains," it was not just poetic licence; although our civilisation has had some shocks since then. Lavater says, "Whoever saw a hero with a small snub nose?" But that is another story. There must have been lots of heroines with a nose of no great significance. We are not concerned with heroes. (Or with noses: "'Tis a pity, said my father, that truth can only be on one side, brother Toby—considering what ingenuity these learned men have all shown in their solutions of noses. Can noses be dissolved? replied my uncle Toby.")

If science is a little shy of dogmatising about the rules of physiognomy, it is probable, nevertheless, that our patients exercise their physiognomical judgment of ourselves. Let me repeat the words of Sir Thomas Browne : " For there are mystically in our faces certain Characters which carry in them the motto of our Souls, wherein he that cannot read A.B.C. may read our natures."

Soon after I went into practice, the wife of an artisan said she knew that I tried to get people well. It gave me rather a shock. I had not thought of any other endeavour. An old man told my senior that I had said his wife was doing well, but that I looked serious. Another patient said that she could not tell, by looking at me, whether or not I was worried about her condition. I assured her that there was no cause for anxiety, but that I should not show it if there were. It was all so different from the medical school days. Although we had been under observation then—particularly by children and old women. In private practice, either general or consulting, our patients study our expression to try to read our natures and our thoughts. We should give them the opportunity of having a good look.

One day when visiting a sick child I said that I liked the trained nurse whom I had met going off duty. My patient told me that she might be clever but that she " fussed her," adding the comment that a nurse ought to be " a comfortable old party." It is nice when going round the wards to have a sister who is used to one's ways, who can prepare a patient for examination, but she must not rush the situation. The physician should take in the whole of the case without fuss, and the patient should examine him, before the physical investigations begin.

There is plenty of scope for the undergraduate medical student in the wards to exercise a wise understanding of illness and to pick up some knowledge of human nature. In my time we used to have one or two cots for children in the general wards. Two or three months after I commenced my clinical work a nice little girl called me " doctor," but a more sophisticated Cockney brat called out : " That's not the doctor that's the ward-clerk." It is not until one has the responsibilities of a resident officer that, what I have called pathognomy at the bedside, can become a practical study. One must begin with delicacy of feeling, without too much assurance ; nothing can be worse than a stare which puts a patient out of countenance.

Ought I to apologise, however, for digging up this word pathognomy ? Was it better in the grave with those from whom I obtained it ? I do not find it in an English medical dictionary and was surprised that it appears in an American medical lexicon, where it is defined as : " The science of the signs by which disease is recognised." This covers a wide field—I did not know. I feel almost sorry that I looked it up. When Humpty Dumpty explained the meaning of his word " impenatrability " he said : " when I make a word do a lot of work like that I always pay it extra."

I have tried to make something of pathognomy in the sense in which the eighteenth century physiognomists used it. To them it was " the motion of physiognomy." The doctor should learn to study his patient's facial expression ; should learn to be under observation himself, without being self-conscious, and to have enough reserve to be able to keep his own counsel, without having a face like Newman Noggs. In diagnosis and treatment he gets the best results who has a receptive countenance.

" Yes," you say, " that may have been all right in your young days, but now we have clinical pathology, radiology, biochemistry, other ancillary services and a psychiatrist, complete with diploma, to study the patient's mind. What did the *Autocrat of the Breakfast-table* say : ' Who wants to hear fanciful people's nonsense ? ' "

You may be right. And yet, if you stand by the bedside studying the countenance for ten or twenty years, a time may come when, of pathognomy, you would use the words which, in another connection, the Red Queen spoke to Alice : " You may call it nonsense if you like, but I've heard nonsense compared with which that would be as sensible as a dictionary."

Guy's Cricket Tour of South Devon

AS a climax of the first season of peace, the Guy's Cricket Club made a tour of South Devon. Eight matches were played, of which 2 were won, 3 lost, and 3 drawn.

If Guy's did not exactly carry all before them on the cricket field, they acquitted themselves with credit, showed a marked tendency to fight back when all was not well and, in general, showed an excellent grasp of the axiom that a game of cricket

is not lost until it is won. And quite apart from colourless figures, the whole party had a thoroughly enjoyable holiday.

Cars and petrol were available to a degree which was profusion after the war years and were indeed essential to the success of the tour, as the matches ranged widely from Exeter to Plymouth. The weather was passable, and even favourable when that prevailing over the greater part of the country was considered. Two matches were curtailed by rain and that at Bovey Tracey was played to a finish in a steady downpour, which was ignored by the local players, hardened to such trials, and even described by some of their veterans as " Quite a fine day ! "

The party was quartered at the Parker's Arms near Paignton where, under the genial supervision of the landlord, they were dined and wined, the latter to such extent as the prevailing drought permitted. In fact there was usually a full turn-out for the excellent breakfast, even after the Devonport game which was memorable more for the festivities following the onset of rain than for any doings at the wicket. And then there was one evening at the Smugglers' Inn, near Dawlish, when—— but this was a cricket tour.

The opening match was against Paignton. Twelve hours rain gave place to brilliant sunshine and a prompt start was made on a drying wicket after lunch. A rather travel-wearied Guy's attack could not press home early successes and Paignton totalled 175 by workmanlike methods. Guy's were quite overawed by a gentleman bowling from the Torquay end, who started his run from somewhere on the promenade and was largely responsible for the return of 6 batsmen for the absurd total of 22. With the large crowd judging the game as good as over, Carton Kelly played the innings of his life. He is always severe on the slow bowler while usually timorous with the faster ball, but on this occasion he drove the fast bowlers with grace and devastating power. He and Billingham added 64 for the 7th wicket. Kelly fell at last, still driving, and retired to a great ovation. Billingham hit a second six and missed a straight one, but Guy's reached three figures and were saved from complete disgrace.

A drawn game with Dartington Hall was marred by rain with Guy's gaining the advantage. Munro and Holmes showed their appreciation of all-day cricket with a sedate second wicket stand of 83, but the quick scorers lost their wickets in attack and the 200 did not materialise. Guy's bowled with little success until a shower gave zest to the pitch, but one of the Hall's opening bats was still there when the rain put an end to affairs.

The feature of the Bovey Tracey game was again the weather. This, however, cannot excuse an inept exhibition of batting, and Guy's were dismissed for under the hundred in a little over two hours. Only Platt showed that enterprise which the rural wicket justified. The men of Bovey made the runs, but not before Russell had shattered a few wickets and the Dartmoor mists had discomfited the fieldsmen.

Played on the lovely Recreation Ground at Torquay, the third match again ended in defeat. Graham had no luck with the toss, but the fortune of weather was favourable. Butler, the Devon County man, gave a great show of effortless driving before he was quite deceived by Nicholson, who bowled long and accurately. Graham persuaded a lot of batsmen to give up their wickets, but Torquay were able to declare. Guy's batting again lacked that solidity necessary to make light of a big score. Platt hit up 43 in 35 minutes and Williams and Trist fought it out, but the last 4 wickets crashed sickeningly for only 2 runs and the game was lost by 64.

The clouds burst at a most interesting point in the United Services match. Guy's were 98 behind with 6 wickets in hand, but time was very much against them. The Services scored steadily with the slow bowlers claiming a regular wicket. Munro and Harvard Davis had 37 on the board in half an hour before tea in reply and went on to 55 before Davis was out, forcing the pace. Three more wickets fell quickly and, with the bowlers on top, Munro, having learned his cricket in Yorkshire, rightly or wrongly, put up the shutters. The clouds gathered over the Hoe and Munro watched Talbot make two exquisite off-drives to the boundary before the rains came.

In delightful weather, victory came at last—over South Devon at Newton Abbot. Talbot, benefiting no doubt from not having shared too freely in the previous day's hospitality, played one of his best innings, which stood out amongst mediocrity. At tea, a total of 103 seemed most inadequate. But the Guy's bowlers would have none of it and Russell wrecked the wickets of the first three batsmen in quick succession. Harvard Davis bowled as well as at any time this season and, with Allanby holding a good catch at the wicket, it only remained for Nicholson to spin off the last ball to dispose of the Devonians for 67.

A close game with the Devon Dumplings followed and when time came anything was possible with Guy's 7 runs behind and their last pair together. The match was distinguished by some fierce and accurate bowling by Russell and another cheery innings by Carton Kelly, which, if not quite up to his Paignton standard, certainly has a more positive effect on the game. The Dumplings began poorly against Russell and Carton Kelly, and 3 men were out for 28. A fifth wicket stand of 40 improved matters for them, but they were all out for 137 an hour before tea. The all-too-familiar disastrous start for Guy's followed—17 for 4—23 for 5—26 for 6. Dyer and Carton Kelly set about the task of saving the game with rare spirit. Kelly struck about him at anything within reach and, while enjoying some luck from the lofted drive, raced to his first fifty for Guy's. Dyer, admirably subduing his usual carefree style to the needs of the occasion, gathered runs steadily at the other end. These two added 88 for the 7th wicket. Kelly was stumped, chasing a ball towards long-on and 20 were still needed when the ninth wicket fell. Nicholson and O'Driscoll played as if opening the innings and really looked like making the runs when stumps were drawn.

The tour ended in blessed sunshine on the Chudleigh ground, set in glorious country and with an outfield to envy. A convincing win for Guy's was the outcome. Williams struck his best form and the local bowlers all over the field, hooking with especial skill and solidity. He was unlucky to miss his century. Almost everyone joined in the fun, and Guy's ran up a big score. Graham again bowled well and, with that invaluable aid, good fielding, the bowlers were soon taking wickets. But time was getting short so Trist, who was captaining the side in this, his last, match for Guy's, bowled up the hill to take the final wicket, Allanby holding a fine catch.

Asked to mention the highlights of this week to talk over in the winter's chill, from the field, one would mention the victory at Newton Abbot, Kelly's innings and catch at Paignton, Russell's bowling throughout and Graham's subtle admixture of faultless length and full toss. Off the field, there was the great regularity with which the Seven Stars at Totnes provided beer when all else was cyder—not the drink for an 11.30 start on the morrow, by the way—the extraordinary patronage paid by some to an establishment in Paignton, which the uninitiated took to be the local equivalent of the Bagatelle, and called (we know not why!) the "Casablanca"; Kelly, performing antics in a Dodgem car three sizes too small for him, and Allenby's hole in one at the long fourteenth during his record round on the putting course.

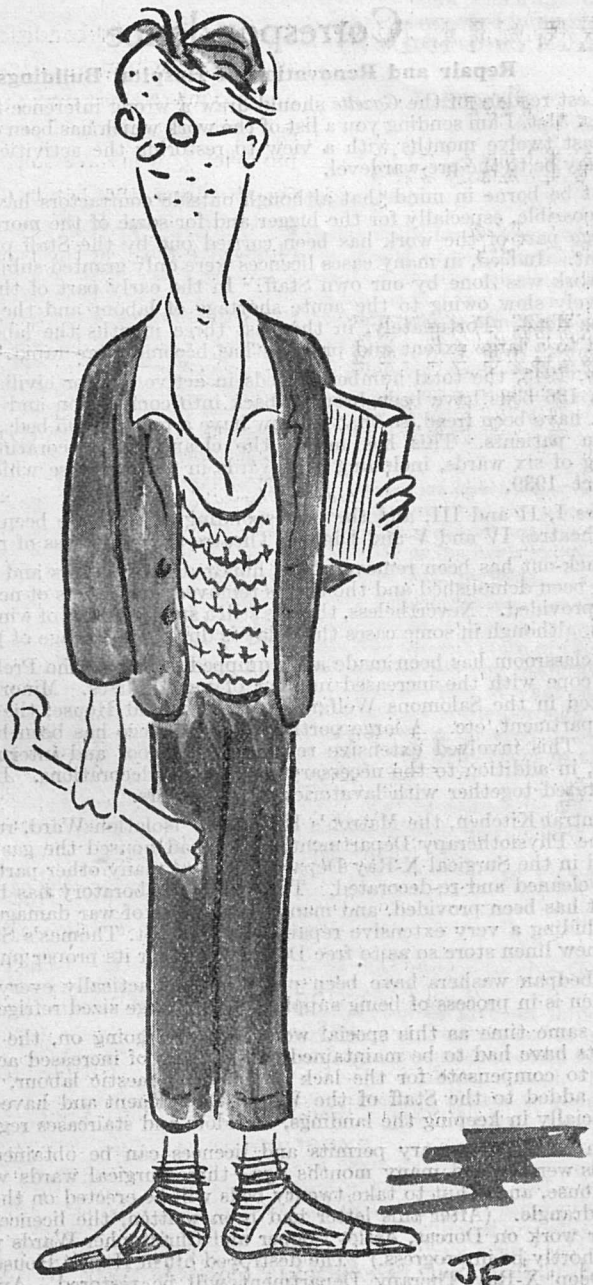
A tour of good cricket and good fun. This must surely be the first of many such, now that the world can again devote itself to all worthwhile things, such as playing cricket.

Those taking part were :—

E. W. Graham (Capt.), J. D. Williams, L. D. Carton Kelly, A. E. Trist, I. A. H. Munro, R. Harvard Davis, A. M. Platt, K. D. Allanby, P. S. Russell, G. P. Billingham, H. M. C. O'Driscoll, R. G. Nicholson, H. E. G. Dyer, P. S. Holmes, C. H. Talbot, C. G. Menzies.

August 10th. (at Paignton).	Paignton, 175. Carton Kelly, 3 for 35; Russell, 3 for 37; Harvard Davis, 3 for 37. Lost by 60 runs.	Guy's, 115. Carton Kelly, 42; Billingham, 37.
August 11th. (at Totnes).	Guy's, 181 for 7 decl. Munro, 54; Holmes, 53. Drawn. Rain.	Dartington Hall, 93 for 5; Carton Kelly, 2 for 11.
August 12th. (at Bovey Tracey).	Guy's, 90. Lost by 6 wkts.	Bovey Tracey, 91 for 4; Russell, 3 for 21.
August 13th. (at Torquay).	Torquay, 176 for 8 decl. G. S. Butler, 65; Graham, 6 for 52. Lost by 64 runs.	Guy's, 112. Platt, 43; Williams, 31.
August 14th. (at Devonport).	United Services, 190. S/A Keeler, 66; Graham, 5 for 40. Drawn. Rain.	Guy's, 93 for 4. Munro 33 not out.
August 15th. (at Newton Abbot).	Guy's, 103. Talbot, 46. Won by 36 runs.	South Devon, 67. Russell 4 for 23; Nicholson, 3 for 19; Harvard Davis 2 for 10.
August 16th. (at Exeter).	Devon Dumplings, 137. D. Henwood, 62; Russell, 6 for 46. Drawn.	Guy's, 130 for 9. Carton Kelly, 63.
August 17th. (at Chudleigh).	Guy's, 246 for 8 decl. Williams, 92; Graham, 30. Won by 134 runs.	Chudleigh, 112. Graham, 5 for 40.

I. A. H. M.



STUDENT TYPES

II. SEMI-NUDIST

Correspondence

Repair and Renovation of Hospital Buildings

SIR,—Lest readers of the *Gazette* should draw a wrong inference from your Passim of Aug. 31st, I am sending you a list of the work which has been carried out during the past twelve months with a view to restoring the activities of the Hospital as far as may be to the pre-war level.

It must be borne in mind that although outside contractors have been employed wherever possible, especially for the bigger and for some of the more specialised jobs, a very large part of the work has been carried out by the Staff of our own Works Department. Indeed, in many cases licences were only granted subject to the proviso that the work was done by our own Staff. In the early part of the period progress was relatively slow owing to the acute shortage of labour and the great amount of work to be done. Fortunately, in the past three months the labour difficulty has diminished to a large extent and progress has become more rapid.

In July, 1945, the total number of beds in active use for civilian cases was 195. Since then 136 beds have been brought back into commission and beds reserved for the E.M.S. have been freed, so that we now have a total of 395 beds, of which 365 are for civilian patients. This has meant the cleaning, re-decorating, re-wiring and re-servicing of six wards, including four wards in Guy's House which have not been in use since 1939.

Theatres I, II and III, and the corresponding offices have been restored and are in use. Theatres IV and V and Diplock Theatre are in process of restoration.

The black-out has been removed from hundreds of windows and skylights. Blast walls have been demolished and the debris removed, and scores of new window frames have been provided. Nevertheless, there is still a small number of windows that require restoration, although in some cases the delay is due to a shortage of plate glass.

A new classroom has been made and equipped to enable the Preliminary Training School to cope with the increased number of pupil nurses. Minor alterations have been effected in the Salomons Welfare Centre, Nuffield House, the York Clinic, the Dental Department, etc. A large portion of the College has been brought back into daily use. This involved extensive repairs to the roof and internal constructional alterations, in addition to the necessary repairs and decorations. In all forty rooms were reinstated together with lavatories and corridors.

The Central Kitchen, the Matron's House, the Isolation Ward, rooms in the basement of the Physiotherapy Department (which had housed the gas decontamination centre) and in the Surgical X-Ray Department, and many other parts of the Hospital have been cleaned and re-decorated. The Clinical Laboratory has been restored and access to it has been provided, and many other items of war damage have been completed, including a very extensive repair to No. 20, St. Thomas's Street, in order to provide a new linen store so as to free Dorcas Ward for its proper purpose.

Steam bedpan washers have been provided in practically every ward, and each ward kitchen is in process of being supplied with a large sized refrigerator.

At the same time as this special work has been going on, the various Hospital departments have had to be maintained on the basis of increased activity, and in an endeavour to compensate for the lack of female domestic labour, cleansing squads have been added to the Staff of the Works Department and have proved of great value, especially in keeping the landings, corridors and staircases regularly cleaned.

As soon as the necessary permits and licences can be obtained—the necessary applications were lodged many months ago—three surgical wards will be reinstated in Guy's House, and a hut to take twenty beds will be erected on the east side of the Front Quadrangle. (After this letter had been written, the licence to enable us to start repair work on Dorcas, Astley Cooper and Christopher Wards was received and work will shortly be in progress.) The destroyed lift in Hunt's House will be replaced and the Deep X-Ray Therapy Department will be restored. Approximately 120 additional beds should become available for use in the course of the ensuing twelve months.

A suite of six, possibly seven, consulting rooms with accommodation for secretaries is in process of being provided in St. Thomas's House, which will in future be known as Keats House, Guy's Hospital.

I have not endeavoured to set out a complete list of work which has been done, is being done, or is contemplated, but I hope that I have succeeded in making it clear that something has been achieved during the past year in spite of very real difficulties.

I am, etc.,

T. B. JOHNSTON,
Superintendent.

Guy's Hospital, S.E.1.
September 19th, 1946.

"Dragons's Teeth Drawn"

SIR,—The Monstrous Belching Dragon at Guy's has daily, for a quarter of a century, flicked upon the raw those that would teach the Health of the People as the aim of medicine, instead of merely lecturing to students upon the details of their own speciality. It is indeed good news to learn that one who is in a key position to remedy this evil has a very raw place and has enrolled himself among the *flagellantes*. We may now feel, but not rest, assured of its correction.

This is more than a matter of expediency. A Guy's man—or woman—who, between the wars, wanted to take part in the move to secure a healthier atmosphere for London has always been faced with the possible retort: "Well! you cannot preach, look at your chimney," as though each of us could stop it if we would, and were responsible for its continued existence.

And are we not? For the Belcher does more than foul the atmosphere of the Boro'. It does the same to the minds of youth that go out into the world thinking these things do not matter and have no part in the practice of medicine, whereas what we need to do is to send out each one as an apostle of health looking upon prevention, in all its aspects, as a part of the clinical care of their patients.

Just as it is useless for us to talk clinical medicine by the bedside unless we produce patients that the students may examine and accept some degree of responsibility, so is it useless for a lecturer to recount in the theatre the present state of the law with regard to pollution of the skies. If they then go out and see the hospital chimney pouring into the air thick columns of carbon to the contradiction of what the lecturer has said and in contradistinction to all the other chimneys in the Borough, they can then but think that what they have just heard has been but poured into them to get through their exams and not given them as a trick to light them in their ways of life.

And so, again, we may welcome the news that our Superintendent is about to put on the whole armour of St. George and to slay this Dragon that molests us.

Yours, etc.,

T. B. LAYTON.

Guy's Hospital, S.E.1.

"Passim"

SIR,—In the "Passim" of the last issue you invited nurses to give their views, regarding the matter raised in the Chaplain's letter.

We would not agree that generally speaking nurses give an impression of cheerlessness—but that was not the point of the letter as you appear to assume in your criticism of it. The writer was recording the fact that nurses become *less cheerful* during their training than when they first come to the Training School. Surely he is in a better position as an independent observer than the Editor to judge in this matter since, as Chaplain, he is in touch with a large number of nurses from the time they enter the Preliminary Training School.

We do agree that nurses do not care to have their recreation organised, but at the same time your suggestion that nurses can visit picture galleries and concert halls is often impracticable—because of shortage of "off duty" time at appropriate times.

Two of the more important reasons for the loss of cheerfulness are:—

(1) The fact that nurses are treated in hospital as school girls.

(2) They are made to feel miserable over petty and unimportant trifles.

For obvious reasons, we consider it discreet to sign ourselves as,

THREE NURSES IN TRAINING.

Nurses' Home,
Guy's Hospital,
London, S.E.1.

SIR,—I have read with much interest your comments upon Mr. McClaughry's letter in which he deals with the problem of nurses' happiness.

As a trained nurse who left Guy's in 1939 after eight years nursing experience I sympathise entirely with the nurse he particularly mentions. I know many others who constantly tell me the same thing. I did "get away" from the profession for a short time as a constable in the Metropolitan Women Police, and subsequently, after marriage, as an A.T.S. officer. In both occupations I found what I had missed in nursing, that off-duty I was assumed to be as capable of looking after myself as I was expected to be able to do for others while on-duty.

There is, in my opinion, a second important factor. All probationers come to hospitals prepared for the work to be hard, dull at first, and exacting emotionally and physically; in order to face this and be happy and contented they need superb leaders of all grades, women who are trained, not only professionally, but in the ways of the world. Is it too much to say that no woman should become a ward or tutor sister under the age of 30 and without experience away from her training hospital, and without a proved ability to train younger women? When dealing with recruits it is so important that they go on duty knowing they will be encouraged in their work and known personally, not subjected to fluctuations of uncertain temper, often due to lack of confidence, and consequently unable to feel any admiration for the standard of work expected and the example set. All sisters should be made to take a full period of off-duty during the day in order that they rest and leave responsibility to their juniors.

It has been said that the type of girl now presenting herself for nursing training is not of the quality that used to come, but can this be so when the achievements in the various branches of war work are considered; long hours of weary watching on searchlight sites miles from anywhere, likewise on balloon and gun sites, weeks and months of nothing but cookhouse fatigues and so on, which I have seen and sometimes done? I think the good material is there, but it is up to the leaders of the profession to rouse themselves and accept their responsibilities in this direction as nobody else can do it.

I am, etc.,

GWENDOLEN MANN.

12, Mortimer Close, S.W.16.

Pastoral Opinion

SIR,—As one of those not so disillusioned angels, I offer a reply to the "Pastoral opinion."

I, too, began with enthusiasm; the daily routine was a novelty which soon became irksome but not to the extent that I could not continue without "potted" recreation of which there was little during those war years.

My contentment depended upon the inevitable variety of life offered by the wards, smoking room, my own retreat with its books and the great Metropolis.

I hope that "amid the encircling gloom" of the nursing staff the patients still survive.

I am, etc.,

PATRICIA W. DAVYS, S.R.N.

Bude, Cornwall.

Senior Dressers

SIR,—May I, as an old Guy's man of the early 90's, express my thanks to you for your courageous Editorials each week in "Passim." It is indeed sad to read in the current issue of the low estate to which the honourable appointment of a dressership at Guy's has now fallen. As you imply, it was a junior appointment of almost world-wide renown for generations. In fact I recollect, during my student days, an overfull bladder being relieved in the Front Surgery by an assistant house-

surgeon, it is true, who performed a supra-pubic puncture. The patient was greatly relieved, but the operator received somewhat of a reprimand for what Captain Marryat would have called an "excess of zeal."

Believe me, dear Sir,
Yours sincerely,
M. ASTON KEY.

14, Clarendon Road,
Southsea.

"Through a Glass Darkly . . ."

Seen this ?
No.
Oh !
What is it ?
Heaven knows !
See anything ?
Well, it looks malignant.
Why ?
Well, it just does. There's a lot of dark stuff.
Might be pigment.
Might be.
Any round cells ?
Oh yes.
There always are.
Where ?
Anywhere—always a lot of round cells.
Pretty important things, round cells.
Oh yes, pretty important all right.
Where does it come from ?
God knows !
Liver ?
Might be.
Of course, it might be heart !
Yes, of course.
Any plasma cells ?
What are they like ?
Oh—typical.
Oh——no.
Giant cells ?
The big ones with spots on ?
Yes.
No.
It's all pretty important though.
What is ?
All this.
Oh yes, of course, all damned important.
Absolutely vital.
Absolutely.
Oh well !
Oh well !

ANON.

P.M.

Dreamt last night I had a dab
At a man who died of dropsy,
Stretched him out upon the slab,
Did a rattling good autopsy.
Thus he lay there, lacerate ;
You will ask me, "Oh alas, *qui* ? "
Answer—irony of fate—
"De Navasquez ! "

R.H. N. L.

Sport

Cricket

GUY'S *v.* STREATHAM.

(Played at Thornton Heath on Sunday, August 25th, 1946.)

Result: Drawn.

Guy's won the toss for a change and elected to bat, with one eye on the state of the pitch and the other on the absence of some members of the team.

One wicket quickly fell and Williams joined Nicholson. By steady batting the two restored the position, so that when Nicholson lifted the ball to a fielder only too eager to catch it, the score stood at 46. Nicholson had contributed 15 very useful runs. Holmes, with some delightful strokes and accurate placing, helped to increase the total and had scored 17 when he was bowled by a good one. Soon after this Williams, with a pull to the boundary, reached his 50, but in trying to reach the boundary again with the next ball was well caught in the deep. Of the remaining Guy's batsmen only Graham reached double figures, and the side was dismissed for 127.

In the field after tea, Guy's started well by sending two men back for 8 runs and a third for only 9 more. But the next batsman proceeded to settle down so that Streatham had reached 50 before Trist, who had been bowling well, made Lloyd misjudge one which took his leg stump.

Rain then stopped play for twenty minutes, unfortunately converting a close game into an inevitable draw.

Team.—E. W. Graham, Williams, Trist, Harvard Davis, Nicholson, Holmes, Dyer, Menzies, Mills, Bingham, Grant.

Scores.—Guy's Hospital, 127 (J. D. Williams 53); Streatham, 97 for 5 wickets (Trist 2 for 34, Bingham 2 for 29).

Hospital Information, etc.

Notices

DEMONSTRATOR IN PHARMACOLOGY.

Applications are invited for the post of Demonstrator in Pharmacology, duties to commence in October, 1946. Commencing salary £450 p.a. with superannuation. Applications should be sent to the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, not later than October 19th, 1946.

PHYSICAL SOCIETY.

The Students Physical Society will hold its opening meeting for the 1946–47 Winter Session on Thursday, October, 10th at 7.30 p.m., in the Preclinical Class Room.

Clinical cases will be demonstrated and discussed. Officers will be elected for the forthcoming year.

PATRICK CLARKSON,
S. LEWELLYN SMITH,
Secretaries.

Papers by Guy's Men

Campbell, Maurice. Congenital Heart Disease. *Clin. J.*, 1946, **75**, 168.

Dowling, G. B., and Another. Treatment of Lupus Vulgaris with calciferol. *Ibid.*, 180.

Change of Address

J. S. Batchelor, F.R.C.S., 97, Harley Street, W.1, and 204, Drake House, Dolphin Square, S.W.1. (Tel.: Welbeck 8395; Victoria 3800).

J. M. Fabricius, Lt. R.A.M.C. (363776), 11, Field Ambulance, B.F. in Greece.

Gurassa, W. P., and Jackson, F. L. A visit to Finland. *Ibid.*, 431.

D. R. Hone, L.D.S., R.C.S., P.O. Box 76, Nairobi, Kenya.

N. L. Lloyd, M.R.C.P., 42, Speer Road, Thames Ditton, Surrey.

Loader, G. S. Some observations on trismus in relation to maxillo-facial surgery. *Brit. Dent. J.*, 1946, **81**, 193.

Townrow, V., and Another. Perforation of the aorta by a foreign body in the œsophagus *J. Laryngol, Otol.*, 1946, **61**, 38.

H. St. H. Vertue, M.D., 37, Tower Road, Orpington, Kent. (Tel.: Orpington 2944).

Whillis, J. Movements of the Tongue in swallowing. *J. Anat.*, 1946, **80**, 115.

Appointments

The title of Professor of Physiology has been conferred on Mr. W. R. Spurrell, F.R.C.S., in respect of the post now held at Guy's Hospital Medical School.

The Services

Mentioned in Dispatches.

In recognition of gallant and distinguished services while a prisoner of war.

Capt. C. S. Pitt, R.A.M.C.

Births

PETT.—On September 15th, 1946, to Marion Pamela and Roger Dixon Pett, L.D.S., of Church Cottage, Ferring-by-Sea, Sussex.—a daughter.

Marriages

NELSON—RODDICK.—On September 14th, 1946, at St. Peter's, Croydon, George F. Nelson, to Betty V. Roddick, S.R.N.

WARREN—PEACOCK.—On March 8th, 1946, at Southwark, Michael D. Warren, to Joan L. Peacock. Religious ceremony at St. Mary's Church, Lambourne, on September 21st, 1946.

WOODALL—PALMER.—On Saturday, September 7th, 1946, at Golder's Green, John Trevor Woodall, to Jenifer Helen Palmer.

ST. GEORGE — BROAD. On September 14th, 1946, at the Pro-Cathedral, Bristol. Surgeon-Lieut. (D) Irwin Tolme Marillier St. George, R.N.V.R., of Chandlers Ford, Hants, to Leontine Geraldine Broad, of Clifton, Bristol.

Deaths

HOLMES.—On September 15th, 1946, at Waverley, Oakdene Road, Godalming, Richard Annesley Holmes, M.R.C.S. (Eng.), L.R.C.P.(Lon.), aged 61 years.

EDS. {R.T.H. D.H.F.

GUY'S HOSPITAL GAZETTE

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PASSIM

AT this season of the year we have an agreeable duty. It is to offer our greetings to those new readers who, having decided their profession, have chosen Guy's as the portal of entry to it. We hope and believe that their decision will prove to be a happy one and hasten to assure them that our welcome is none the less warm because it is presented each recurring October, unromantic, uneffusive and often unread.

If it is difficult to discover why a man wants to be a doctor, and we may discount the poetic replies given to this inappropriate question at the selection committee, it is yet more imponderable why he should elect to enter this or that medical school. The factors are legion and would make a most interesting not to say revealing study but this much is certain : that a famous hospital's name is as important to a young doctor as a regiment's is to the soldier.

We have talked on one or two occasions to new students and have been a little surprised if not piqued to find that their first impressions of the hospital are disappointing. Quite what they expected to find is not clear, but it seems that each had a picture which varied in its proportions between two extremes. At the one, the son of an old Guy's man had thought to come to a most dignified foundation, imperturble and imperishable, in which all the members of the staff were like the late Mr. Jacobson about whom his father had told him. At the other, an imaginative young man given to reading magazines had dreamed of what in our ignorance we can take to be only some sort of a Mayo Clinic.

New Guy's man, your hospital is none of these ; but before you condemn or condone let us presume for a moment to tell you something of your alma mater. You will suck her generous paps for the next few years and she will expect you to learn to know her, that your appreciation may engender affection.

The first impression comes from the hospital's outward appearance ; scarred, patched and grimed. There is only one feature of architectural beauty here and it is the oldest part. Guy's House comprising the front quadrangle, the collonade and surgical block still stands though mauled severely by bombs. You would be surprised to hear that before the war there were some, and most of them are still here, who sought to have this treasure, which alone distinguishes us from London Bridge Station, pulled down. They believed the false doctrine that a thing's beauty is no more than the expression of its function and thought that surgery was best practised in a factory from the Great West Road. We suggest you look at Nuffield House, the Pathology Block and the York Clinic and then be thankful that in the building of the new hospital part at least of Guy's House is to be preserved. By now you will have begun to wonder why the park is so ill-kept. It was not always so and even before the war Charles Lamb with his love of the Temple might well have envied us our oasis. This despoilment would be indefensible anywhere, but how much more in a place where the return from sickness to health is as dependent on delight to the eye as on physick in the belly.

These are the material things of the hospital. The discomforts of the college, the pervading drabness and shabbiness of your surroundings are partly a legacy of war and will be overcome sooner than later. Meanwhile be encouraged by what our predecessors in nineteen thirty-seven called the "insidious mental inertia" which will settle upon you and numb your critical faculties. Unknowingly this blessed state will make you oblivious of anything being wrong and will be the first step in your achieving what the outside world first notices in a Guy's man, insularity and self-satisfaction.

Whether you have come from the services or from school you will quickly notice that discipline in the enforced sense is minimal. Neither the sergeant-major nor the schoolmaster is in evidence, for it has always been assumed that their lessons have been learned before a man comes here. With reference to this it is disquieting to hear observers, returned to Guy's after several years' absence, say that courtesy and good manners both among staff and students are at a low ebb. A very distinguished old Guy's man wrote to us recently declaring that a provincial consultant friend of his had, in respect of these qualities, placed us low on the list of teaching hospitals from which he had had housemen during the war. It may be part of the general deterioration throughout the country but it is at once noticed by patients and particularly by hospital patients. Again, the student is not driven to work hard except in so far as the threat of being called-up now overhangs him if he fail his examinations. In our view it is a pity that many to-day work as hard as they do, earning the name, which a friend of ours has coined, of ant-heaps. We risk being on dangerous ground and pointing the finger of self-accusation when we say that it may be no bad thing for a doctor to know as much about the world and his fellow men as it is for him to have absorbed the second-hand knowledge of his text-books from cover to cover.

Teaching at Guy's is above all practical. Someone has said that the hospital's reputation depends not on those who stay here but upon those who go away as ambassadors. That being so the authorities have always set their face against the introduction of fads and fancies with the result that medically we worship the idol of orthodoxy here. This earns scorn from many quarters and not least from the rival priesthood of science. These are the people who advocate the teaching of human anatomy by biologists without a medical qualification and would transform the ward into a laboratory if they could. But in repelling these impertinant encroachments many believe that Guy's has failed to make use of all the tools with which medicine is practised and that secure in the traditions of her great clinicians and observers has not been as selective in her conservatism as once Professor Johnston maintained she was. You will notice that specialists are more than suspect here ; that most people claim to be either general physicians or general surgeons although the latter have never seemed to hear the charge levelled at them by a well-known and by no means inaudible throat surgeon that they are little more than limited abdominologists. We have no neuro-surgeon at Guy's and though there is a distinguished thoracic surgeon no department or unit of thoracic surgery exists. It may be that these are not desirable and that because others have them that is a reason why we should not. On the other hand beds are pitifully short just now and in an undergraduate hospital there is no room for luxuries. Yet you will find that your teachers are very much in touch with modern work and by their orthodoxy try it as by fire. There are few if any whose wisdom of the years has become so ripe that fermentation has set in, or of whom it might be said, in the words of the late Sir Clifford Allbutt, they have reached "that state of mind which seems mellow wisdom to its owner, but appears to the younger generation as senile obstinacy." We have said that you will not be made to work. But it may be pointed out that whether or no you choose to learn at the bedside is your own affair. It is a custom that any student may enter the wards at five o'clock to examine patients or watch the housemen undertake minor procedures. This pleasant mode of acquiring knowledge saves endless dull hours of book-work and is the answer to those who think that Guy's is some sort of a polytechnic where on payment of a fee knowledge is ground out over a period of six years, at the end of which one more doctor is produced.

So much for teacher and taught. Perhaps as important a part of any teaching hospital is the patient. He allows himself to be the instrument of instruction, being examined, sometimes painfully for him, a multitude of times especially if he is unfortunate enough to be considered interesting. You will find here both as out-patients and in the wards the people of the Borough, of Bermondsey, Rotherhithe and the Old Kent Road. Of them we cannot speak too highly and in any event they would resent compliments. They are as clearly defined a people as those of any county in the country and we would strongly recommend our new readers to become familiar with the several taverns around the hospital and there meet and talk with these most estimable folk. They will then realise that Giles' cartoons are in every respect accurate.

On other pages you will read of the many clubs which cater for all tastes. Notwithstanding, you will find among your fellows demagogues who will repeat that there is no opportunity for indulging interests outside the daily work. We believe that the facts are these. Anyone who really has any interest outside his work can pursue it without difficulty either at the hospital or in London. Of those who have

no outside interests, some do not want any and the rest do not know what they want. A man's interests come from within and only partly from without. Others say that the school being affiliated to London University ought to take more share in University affairs. Where a university is dominated completely by a metropolis it is little more than an examining body. It seems to us futile to pretend that the widely scattered medical schools and colleges of London are in any sense a university except in name; the real focus of activity is here at Guy's which after all has about eight or nine hundred medical and dental students.

Lastly, we come to a very solemn subject. You who have come to Guy's this year are the last to know the hospital as a place of medical education for men alone. The Goodenough report recommended the Government to withhold the University grant from schools unwilling to accept a proportion of women students. Next year the first interlopers will join us. Fifteen per cent is the proportion allotted but, have no doubt, the wedge will be pushed in and the number increased. Every form of argument and feminine wile will be used and we, in our weakness, shall give way. And rest assured of this: that if ever the embargo of a limited proportion be lifted and if examination attainments still remain the criterion of selection of medical students there will be few men here at all in future years. For the girl under twenty is less deflected in her purpose than the boy and always a better academic sponge. We have said before and we say it now that the character of the life at Guy's with its old robustness and its customs must change when the Trojan horse is let in. If it does not it would be a condemnation both of the men and of the women who will be not a persecuted but a highly-favoured few. It will fall to you to face the tragedy but you will have the sympathy of the great majority of old Guy's men, thankful never to have seen the fateful day themselves.

It is the pleasing way here that, while criticism is encouraged from high and low about all and sundry in the hospital yet outside voices are stilled and we appear to be rather proud of both Guy's and ourselves. The place will grow on you and when your turn comes to leave, we prophesy you will not go gladly.

Medical Learning and Medical Language

By H. St. H. VERTUE.

THE WORD VIRGIN, said the schoolboy, is derived from vir, a man, and gin, a trap, meaning man-trap. Inasmuch as the bulk of our profession nowadays knows as little about the meaning and derivation of words as the schoolboy and perhaps cares less, there have sprung up of recent years additions to our vocabulary that all too plainly betray this want of knowledge and lack of interest, and disclose at the same time a most peculiar absence of taste. The causes of this decline of culture are too many and complicated to be gone into, except very briefly; but first and foremost I should put the disaster that befell us many years ago when education began to be cut short before it was completed and training for a career prematurely put in its place. Until a youth is well on his 'teens, it is unlikely that he will have understood anything much of what he has been taught. But at about this age there should burst upon his vision a new world of wonder and delight, to which he finds himself all unexpectedly the heir; now all should have its meaning and all the arduous preliminary toil seem well worth the undergoing; and yet it is now that he is all too often taken away from his studies, and if his future is to be Medicine, set to the medical curriculum. As this calamitous process has been going on for many years by now with greater and greater stringency, one has to confess that the profession is becoming more and more composed of half-educated men. Ask a student what chorea means, and

He'll smile and look politely round
To catch a casual suggestion;
But make no effort to propound
Any solution of the question.

Ask him if he knows Horace's Ode about Soracte (nec dulces amores sperne, puer, neque tu choreas), and he'll laugh decorously at the absurdity of the suggestion. Now I should be the last to decry the beauty of Science or its excellent effect in training the mind, yet it should be added to these things, not replace them.

When the student laughs, we see the mental process called "projection." To a man of no means wealth is wickedness; and so it is the millionaire who fills the role

of corpse in the detective story: he may be killed and scarce one will be offended. To Dickens, a man of humble origin, a gentleman was no more than Mr. Chester, nor a lady than Edith Skewton; and never all his life would he learn better. So to the man of no culture learning itself is undesirable. Nay, does he not plead that all that counts is "efficiency," word beloved of the uncultured? Thus *Errour* reproduces herself, and was a female in the Faerie Queene, suckling a thousand young from her poisonous dugs. Yet supposing that a young man of promise in his profession were to send the radiographer on a quest for "platysbasia," that is flat (Gk.) kisses (L.), should we not say that he was thereby discrediting Medicine? And does not the credit of Medicine matter very greatly? Contemplating the use of such a word one is seized with a sharp pang of dismal apprehension that Medicine will soon forfeit her position as a member of the learned professions.

Not that it is all our fault. Until some forty years ago it was believed that a poor man should be relieved of his poverty, but it was not believed that wealth well gotten should not be possessed. Shelley, whose philanthropy none will impugn, wrote:

> What men gain fairly, that they should possess;
> And children may inherit idleness.

But now the notion is that none may have anything that all the others cannot have as well. Politicians have been busy putting this idea into shape, and two terrible wars in a generation have accelerated the process. Oppressed with death duties and penal taxation, the father has no longer been able to afford to complete his son's education, but has had to put him instead to a training which, however excellent, is still utilitarian. The whole level of the higher culture has fallen at the same time. Gone are fine houses and beautiful gardens, libraries of books, exquisite courtesies and polished sensibilities, the heritage of centuries. Of course a considerable sacrifice would have had to be made and would have been gladly made, for the sake of fellow men; but this was not enough to appease the passion of the day: all had to go. With the old culture went coolness, courage, perspicacity, firm judgment and indifference to popular clamour, qualities that physician and surgeon can ill spare.

> Iustum et tenacem propositi virum
> Non civium ardor prava inbentium,
> Non vultus instantis tyranni
> Mente quatit solida.

It is not profoundly significant that in her hour of gravest peril England turned to a man of the old culture, who alone could save her? Is it not equally significant that, the danger past, when the crown of his achievement was almost in his grasp, he and those men of honour and ability, who together with him carried their country through from frightful jeopardy to victorious success and thereby deserved nought less than a nation's heartfelt gratitude, were cast aside with an appalling levity?

> Filial ingratitude!
> Is it not as this mouth should tear this hand
> For lifting food to't?

Unless there is a complete reversal, no such man can arise again. The tragedy of England, did she but know, may be the destruction of her old culture; the loss of *her* culture may be the tragedy of Medicine, writ smaller.

We owe it to ourselves to be able to stand steadfast in a world that is slipping about us; we owe it not less to our patients, who need and look for symbols of power in us, even though, the illness over and the fear gone, they may sometimes be jealous of them. When the divinely gifted Shelley was undergoing the incomprehensible agonies of childish persecution, he had but one friend, Dr. Lind, physician of Eton, afterwards lovingly portrayed as Zonoras in Prince Athanase.

> And he filled
> From fountains pure, nigh overgrown and lost,
>
> The spirit of Prince Athanase, a child,
> With soul-sustaining songs of ancient lore
> And philosophic wisdom, clear and mild.
>
> And sweet and subtle talk they evermore,
> The pupil and the master, shared.

Could it be said, with any approach to honesty, that we should be likely to fulfil Shelley's need to-day ?

I have gathered together a few out of the very many vile words that are in constant use, a mere sample, just to show to what Medical learning has come. Let Medicine look in the glass but a moment and see what sort of a face hers has become !

SINUS.

The uses to which this unfortunate word are put illustrate better than any the degradation of the medical vocabulary.

A Sinusoidal Current is, I believe, one of the very worst terms in use. Sinusoidal is a compound word, and the stem of the prefix, sinu–, should have been used ; instead of that it is the nominative case sinus, a gross error. After this comes the otiose vowel –o–. What is it doing ? Next there is a change to the Greek language with –id–, that is eidos an appearance; and then a shift back to Latin with the adjectival suffix–alis. Lastly, the word is always mispronounced with the first i long. Five howlers in one word of moderate length ! If we wish to convey the meaning of likeness to something in the form of a Latin adjective, we use the stem of the word intended followed by the suffix-iformis, for instance the restiform body, the vermiform appendix, and the nuciform sac of Cutler Walpole. So this should be a sinuiform current, with a short *i*.

Sinusitis is only less bad because it is not so long. The first *i* is mispronounced in the same way and the same mistake is made of joining up the nominative case as the prefix instead of the stem. Then there is the same uncouth conjunction of Latin and Greek. It may be as well to emphasise in passing that –itis does *not* mean " inflammation " : it is simply a Greek adjectival form, for instance splenitis, of or pertaining to the spleen. Often some word such as nosos, disease, is understood with it, for instance nephritis (nosos), kidney disease, of a particular sort. Sinus is not Greek ; even sinuitis would therefore be incorrect, and " Inflammation of Sinuses " is clearly the expression to use.

The Sino-auricular Node.—Here the compound adjective is formed correctly from a stem sino– ; but sino– is the stem of sinum, a large drinking vessel with curved sides. Of course this is not meant, and sino– is a ridiculous howler for sinu–, meaning here a channel. So it should be the sinu-auricular node, with the first –*i*– pronounced short.

–OSIS.

As there are many medical minds labouring under the belief that –itis means inflammation, so there are as many men deluded who suppose that –osis stands for degeneration. Nothing of the sort ! It is a Greek suffix denoting action or condition, and is properly formed from verbs in –oö. From metamorphoö, I change the shape, comes metamorphosis ; from psiloo, I strip bare, comes psilosis, an allusion to the raw tongue of sprue ; from phimoö, I muzzle, phimosis, and so on. Adjectives with stems in –o– are also used, with less authority, for instance cyanos giving us cyanosis and chloros chlorosis, conditions of blueness and yellowish greenness respectively. Ochros should have given us ochrosis : " ochronosis " is an inexplicable mistake. But what are we to say of such a word as *nephrosis* ? What can it mean ? Kidneyness ? Kidneyfication ? There is no escaping the conclusion that to use this word with an intended meaning " degeneration of kidney " is to betray extreme ignorance or indifference about the meaning of words. And so it is with *osteo-arthrosis*, " bone-jointiness," and *paradentosis*, " beside-toothing." Generally speaking the Greek usage was to form words in –osis from verbs with stem –*o*–, as aforesaid, much more rarely from adjectives with stem –o–, for instance typhlosis from typhlos, and not at all from substantives. Therefore, such words as *leucocytosir* are doubtfully correct. As for *asbestosis*, it means unquenchability. There are many words in the medical vocabulary in –osis now, and it is time that they had a drastic revision

–IZE.

The Greek suffix izein forms verbs that denote to act as, to play the part of, to practise or to do things in the manner of the word derived. Traulos is a lisp, and traulizein is to act in a lisping way, to have a lisp. Psithuros is a whisper, and psithurizein is to have a whispering way, or simply to whisper. Philippizein is to do things in Phillip's way, to be what we should now call a Quisling. Not very often the verbs are transitive. Baptein is to dip, and baptizein is to make a practice of

dipping (persons). Many coinages from Greek words have been made in English in this way, organize, harmonize for instance. These are correct enough, but when the coinage is from an English or a Latin word and the Greek suffix, then the result is a grotesque. To Bowdlerize (to cut out all the naughty bits), to Froudize (to make indiscreet revelations), a minimizing strain, a formalizing tendency, these innovations the Greeks themselves began to extend the meaning from that of doing something in the manner of an agent to that of doing something *with* an agent, for instance pschizein, to do things with pebbles, to vote or count; and this cheap and easy method of market-place and assembly, comic poet and popular speech, since imitated in that reflection, has been the geniture of a rabble of base-born verbs. A careful man, however, one who loved his language, would eschew all such. Ready enough to ostracize or stigmatize, and of necessity sometimes having to vapourize or standardize, and rarely perhaps to colonize, subsidize or fraternize, he would yet be reluctant to regularize or familiarize, would be wary of realize, and would scorn altogether to utilize such a misbegotten word as *hospitalize*.

Hostis is primarily a stranger, and a hostipets or hospes is one who cares for strangers. With the adjectival form hospitalis understand domus, and you have a hospital, the house that cares for strangers. To join together the Latin hospitalis (or English hospital) and the Greek suffix –ize, is to manufacture yet another of those insufferable words that disfigure the medical vocabulary.

> Humano capiti cervicem pictor equinam
> iungere si velit, et varias inducere plumas
> undique collatis membris, ut turpiter atrum
> desinat in piscem mulier formosa superne,
> spectatum admissi risum teneatis, amici ?

Believe me, good Pisos, such a word as hospitalize is no less preposterous than the picture of Horace's fancy. If a meaning in it could be admitted at all, it would be to play the part of a hospital; and it might be used as legitimate slang in speaking slightingly of a quack institution. But in fact it is used in the passive voice with the intended meaning of to be in hospital, to be admitted to hospital or to be too fond of hospital. None of these ought it to be supposed to bear: indeed it never ought to be used at all. To say that a person "hospitated," who sojourned in hospital, would just pass: *hospitari* is to sojourn. It would be grammar, but it would be hideous. How much better to use plain English and say just what was meant !

Another barbarous word of the same sort, which is in common use, is to *digitalize*. If a physician were to digitalize, he would act as a foxglove or do the things a foxglove does; that is he would throw up a stem four feet high, burst into bells and woolly leaves and secrete the appropriate glucosides. Clearly he cannot do these things; neither can a patient have them done to him. He cannot therefore *be digitalized*. When this vile expression is used the meaning usually intended is that the patient was given digitalis, or given digitalis effectively: then why cannot this be said ?

"THE VITTAMINNS."

Standing beside the bed of an experienced nurse, who was long in recovering from influenza, I asked her whether she was having any Vitamine A. Her face was perfectly blank in response. "Vittaminns ?" kindly translated the Sister; and all was clear. Casimir Funk, the inventor of the word, christened the body he discovered (B1 that is) a vitamine, because it was an amine, and because it was necessary for life, vita. True enough other bodies of the same sort are not amines, and so I suppose the final –e came to be dropped; but the word as it now stands, "vitamin," means nothing at all. As for the common pronunciation "vittaminn," vitta means a snood: vitamines have nothing to do with snoods. *Avitaminosis* is a bellyful of errors, and it ought to come right out. For the now meaningless "vitamin" a new word is needed. I suggest epicurema (pl. epicuremata) from epikoureo, I go to the aid of, I act as an ally, a word that conveys the double meaning of "protective and accessory."

IODISM AND BROMISM.

These two are apt examples of medical carelessness about words. The parent word iodine is a corrupt form derived from ion a violet and eidos appearance, an allusion to the colour of the element. To ascribe to a person iodism is to imply that he looks like a violet. Yet by some incomprehensible process of thought, or perhaps by total lack of it, the meaning arrived at is an excess of iodine in the body. To the

ill word bromism a similar sort of meaning is attached. But bromos is a stench, more particularly the stench of a rutting male animal. Bromism therefore—but the rest let imagination do. To denote these two conditions correctly one might say pleonasmus iodinæ and pleonasmus brominæ, assuming that the two volatile elements are feminine, as their names, like Geraldine's and Evangeline's, seem to imply. But it is strange that Medicine, following its usual rather dubious methods, has not at least thought of hyperiodinism and hyperbrominism.

To anyone interested in language scores of words will occur as things due for revision or deletion from the medical vocabulary, but these few instances out of very many will have to do for the present. Many worthy folk, so they say, dwell in the township of Soloi, where the solecisms come from, though the climate is rude and the barbarians somewhat uncomfortably near, but I can recommend Athens as an altogether more congenial place for those who wish to cultivate to the best the minds with which Nature has endowed them.

To Those About to Enter the Medical Wards

By Sir JOHN CONYBEARE, K.B.E., F.R.C.P.

SINCE the institution of the Preliminary Clinical Period about fifteen years ago, students starting their ward work as first three-month medical ward clerks are already familiar with the routine methods of examination and some knowledge, perhaps mainly theoretical, of physical signs. They have also had some instruction in clinical pathology and are in a position to realise that in certain types of case pathological investigations play an essential part in diagnosis.

There are, however, very real differences between the patients seen in the Preclinical Classroom and those who are in the beds in the medical wards. The former are relatively fit and come up to be examined because they have well marked physical signs. Moreover, they are paid to come up and are prepared for any amount of examination. The ward patients, on the other hand, have entered the hospital, not as material for students to examine, but because they are ill and in need of treatment. Moreover, far from being paid to come in many of them are paying directly, or indirectly, for their treatment in hospital.

Students in the preliminary clinical period naturally take but scanty interest in the patients they examine, except in so far as they are good examples of an objective lesion, whether it be mitral stenosis, a fibroid lung, or a lump in the belly. In the patient as a whole they are not greatly interested.

On entering the medical wards the relationship between student and patient is of quite a different order. The ward clerk should now regard himself as almost the family doctor to his patients. He must be familiar with every aspect of their case and with all the factors, economic, domestic and social, which have a bearing on their illness. The ward clerk is often able to obtain the confidence of his patient more completely than can even the House Physician and he is, therefore, often in a position in which he can help to allay apprehension and anxiety.

Before further discussion of the value of the appointment of medical ward clerk it is perhaps appropriate here to stress a few practical points.

In the first place students should realise that the Governors have laid down that the wards shall be closed to students before 10.0 a.m., between 12.30 and 1.30 p.m., and between 4.0 and 4.45 p.m., and after 7.0 p.m. In other words the wards are open all day except for two relatively short periods. This does not, however, mean that any individual patient is available for examination at any particular moment. The patient may be being washed or fed and needless to say the ward clerk will co-operate with the nursing staff in so timing his examinations that they do not clash with nursing duties.

The ward clerk is responsible for the ward report. May I urge him to be particularly careful to fill up the details on the front page, giving the patient's full name and address, the name and address of his doctor and other important details. It is always possible that at a later date someone may want to follow up the case and nothing is more infuriating than to find relevant information missing owing to the carelessness of a ward clerk.

Students have only six months of clerkship in the medical wards, which compare with nine months of general surgery. These six months are probably the most important in the whole of the medical curriculum. It is only during this period that the student has real and unrestricted access to patients. True he can go on ward rounds at later periods but he is then a "foreign body," who will have little or no opportunity of examining a patient. It is, therefore, most important that every medical ward clerk should make full use of his opportunities of clinical study of cases and nothing should be allowed to interfere with this object.

Books can be read at any time but the opportunities for obtaining clinical experience of cases is limited. Therefore never waste time in reading at a time when you might be seeing cases. During the medical ward clerk appointment no attempt should be made to read medicine systematically. It is far better to read up the text-book accounts of diseases which you have encountered in the wards. If possible, read them up in more than one book and see how the text-book descriptions fit in with the cases you actually see.

During six months as a medical ward clerk you will have seen examples of practically every medical condition which is frequent or important. Some of the varities you may not happen to remember, for instance Addison's disease or hæmochromatosis, but the great majority of diseases you will have seen. If these have been read up there will not be very great deficiencies in your text-book knowledge at the end of six months.

There is, however, a proviso to what has been said above. Though the patients in your own beds are your special charge and responsibility, it is equally important that you should be familiar with cases in the beds allocated to your fellow ward clerks. Though you are not responsible for their ward reports you should certainly know the full history and details of every case in the ward, and if the patient has abnormal physical signs you should have examined him preferably in association with his own ward clerk. In other words, knowledge of your own cases is not enough. You must know every case in the beds allocated to the firm and be personally familiar with any physical signs that are present.

If any of your own patients need some special examination, whether it be a lumbar puncture, a blood transfusion, a bronchoscopy, or an aspiration, it is your duty and privilege to be present and the responsibility for finding out the time and place is yours. Hence it is important to keep close and friendly relations with the house physician and the nursing staff. If you are a constant attendant on these occasions at the worst you will get a first-hand demonstration of what is being done, at the best you may be allowed to perform the operation yourself under supervision.

It is also advisable to keep in touch with your friends on other medical firms. By so doing you may be enabled to see cases of special interest or rarity.

Cases you have seen during your period as medical ward clerk are going to form the basis of your knowledge of medicine. There is much to be said for keeping personal notes of the interesting cases you see, either on some form of card or in a loose-leaf note book. You can then index the cases by diseases and of course add to your collection such cases as you encounter later. Notes of this kind are of great value, especially if they include the comments of registrars and members of the staff who have seen the patient.

Your period as a medical ward clerk is that in which you should acquire a real familiarity with physical signs. In spite of the great advances in accessory aids to diagnosis, such as X-rays, physical signs are still important and significant, though it must be admitted that absence of abnormal physical signs means little or nothing.

Unfortunately, physical signs are difficult and can be learnt not from books but only from assiduous personal experience. Though you may have been taught something about physical signs in the preliminary clinical period class, it is during your six months as a ward clerk that your real opportunities for hearning murmurs and other physical signs in the chest are available. If you fail to make use of them it is going to be extremely difficult to find similar opportunities at a later date. Remember, too, that even from the purely material point of view of success in examinations a failure to recognise aortic or mitral murmur will quite rightly often lead to failure. Therefore take every possible opportunity of listening to hearts and lungs, not in the rush of ward rounds but at quiet times, for instance after tea.

During the last few months arrangements have been made for medical ward clerks to have a "take-in," comparable to that of dressers on the surgical side. This innovation will give the "take-in" clerks an opportunity of seeing medical emergencies immediately on their admission to hospital. In order to obtain full value from this period of residence it is essential for the "take-in" ward clerk to be immediately available and to keep in close touch with his house physician.

It is also the duty of medical ward clerks to be present at medical out-patients. Here they have unequalled opportunities of examining patients and trying to arrive at a provisional diagnosis. In return they should make certain that the urine is examined in every case and adequate notes made in the out-patient letter. A keen and intelligent firm can greatly lighten the task of the physician.

To Those About to Enter the Surgical Wards

By H. J. B. ATKINS, D.M., M.Ch.(Oxon.), F.R.C.S.

FIRST let me extend to you a very warm welcome. After years of preparation you are now ready to start playing your part in the real job of a doctor's life—to help his patients to get well. At first you may find that the atmosphere of the wards is strange after that of the medical school, and it will take you a little time before you feel at home there. When you were in the medical school you were the centre of attraction, the very buildings were erected for the express purpose of housing you, and the activities of the entire institution were directed for your benefit; now that you are in the wards you will have to take second place to the patients. The wards were not built for you, but for the patients; the nursing staff are not primarily interested in your education (though they will often do a lot to help you) but in the patients, and it is in the constant service of your patients that you will, almost incidentally, absorb that knowledge and skill which will make you a good doctor—honest, sensible, practical and keen, in fact everything that we like to think implied by the title—"a Guy's man."

What a pity we cannot revive the old expression, "walking the wards!" Nowadays, I fear, the student's career would be more fittingly described as "sitting the lecture theatre." Spend all the time you can in the wards and at Out-Patients and see and do everything that you can yourself. Don't think that you will have a better chance of passing your examinations if you spend hours reading that should be devoted to clinical work.

Although in the last analysis you can only learn clinical surgery through your own efforts, you will nevertheless receive plenty of instruction. The good doctor must be able to think for himself, but in order to think profitably about surgical matters and not to indulge in dangerous theorising it is necessary to be in possession of facts. A part of your education will therefore consist in factual teaching. This is usually done by the registrar to your firm who will at the same time take pains to see that you know how to examine a case properly and to elicit physical signs with confidence. For the most part the registrar will lead you from the particular to the general; "here is a case of acute appendicitis, let us see what we can learn about acute appendicitis in general taking this particular case as a context." On the other hand, you will also receive teaching from members of the staff. This teaching should be, and usually is, different in type. In the first place it would be redundant for the consultant to go over in the afternoon the same ground which has been covered by the registrar in the morning; in the second place, those attending these rounds are at different levels of surgical education, and lastly, the member of the staff should be able in virtue of his seniority to communicate, from his store of experience, knowledge which is not to be found in the books. These rounds proceed usually from the general to the particular. The individual problems of the particular patient are discussed, the case is analysed in greater detail and the result is an essential complement to the systematic teaching of the registrar. It is not, however, alone by what they tell you that you will learn from the senior members of the staff. Sir Arbuthnot Lane was in many ways a great surgical teacher, though he rarely indulged in what would commonly be regarded as academic teaching. There is such a thing as teaching by precept and you will learn much by quiet observation. Observe how a surgeon twenty or thirty years your senior will spend three times as long as you did over taking the history of a patient and in his clinical examination before he presumes

to make a diagnosis. Remember what points in the history he elicited and which were significant, what physical signs he found and to which he paid the greatest attention. Try to follow the mental processes involved in solving a difficult diagnostic problem and then apply these methods to your own problems.

Now let us consider the vexed question of time spent in the operating theatre As a student I spent long hours standing first on one leg and then on the other watching operations, the details of which were quite beyond me and which the majority of my contemporaries would never perform. I became the most enthusiastic advocate of the "banish the students from the theatre" movement which is being pursued so actively to-day. Nevertheless, I believe that the pendulum may swing too far the other way. It is part of every doctor's education to know the ritual of asepsis, to see what surgery can do, to appreciate the difficulties, and above all to catch something of that spirit of strenuous, disciplined endeavour which is the atmosphere of the operating theatre. There more than anywhere else you will learn to appreciate the grave responsibilities of your calling. In the theatre, too, you will be able to study what Lord Moynihan termed "the pathology of the living," and you will be able to interpret with startling clarity the value of your physical signs, to be heartened by your correct diagnoses and to learn from your mistakes. That, incidentally, you may have to act as a porter means that you are for the first time learning that a doctor's duty consists not infrequently in putting himself to some personal inconvenience and bodily exertion to be of practical service to his patients.

You must undoubtedly attend when your own cases are being operated upon in order that the notes of the operation may be written intelligently. When you do this you will probably be allowed to "wash up" and the complicated details of modern asepsis will be explained to you. Furthermore, when you are "washed up" you will be able to stand up to the table and get a really good view of what is going on. Otherwise I should advise you to attend in the theatre whenever an operation is being performed which you have not seen before, and always where shortage of porters would otherwise entail lifting and heavy work on the part of the nursing staff whose duties it should be your constant endeavour to lighten.

As surgery becomes more and more professional in its exacting demands, there is an increasing tendency to relegate all but a few privileged spectators to the balcony, so that much of your watching will be done from there. It is intended to remodel the theatre balconies, enclose them in glass, step them forward at the sides and provide microphonic communication from the operating table, so that you will be able to see more clearly what is going on, and essential points of anatomy and pathology will be demonstrated to you during the course of the operation. Nevertheless, you will often be in the body of the theatre, and I propose, therefore, to say a word about theatre manners. If you are "washed up," remember that everything, including the skirt of your "sterile" gown, below the waist must be considered unsterile. Keep your hands high therefore and away from any possibility of contamination. If you are not "washed up" wear a bandage as a belt round your gown so that it does not billow, and give every person or article which is sterile a wide berth. You may see a hundred operations run smoothly, but sooner or later you will witness a tragedy. If it is only the thousandth case, remember that that thousandth is somebody's father, or wife, or child and you want to be quite sure that by your demeanour and conduct you have not in the slightest degree contributed to the tragedy. In the theatre "silence is golden." There is nothing more distracting to the surgeon than to half hear a whispered conversation at the back of the theatre. You would not do it on the eighteenth green when you were watching the crucial three-yard put that was to win the Open Championship; don't do it in the theatre where the results are not so publicised but are of greater consequence.

At all times do what you can for visitors to the hospital. When you go abroad you will find that, however lowly your status, you will be treated by world-famous surgeons and professors with that deference and consideration due to a visitor. In England we have a bad reputation for indifference in this respect, and it is up to us all to exorcise this spirit. Greet a medical visitor to the hospital as you would a guest in your own house. See that he is directed to where he wishes to go, if possible accompanying him yourself; in the theatre make sure that he is provided with cap, gown and mask, and that he is so placed that he can get an uninterrupted view of the operation which he may have travelled three thousand miles to see. Inform the surgeon who is operating that there is a visitor in the theatre and if possible give his

name ; arrange for him to take tea or coffee, and in fact treat him as the friend which, within the freemasonry of medicine, he undoubtedly is.

Finally, remember that you are an integral part of a world famous hospital. that you are a Guy's man and that the reputation of Guy's is in your hands. I believe that this hospital is moving to a period of greatness and you are privileged to be participators. Work as you have never worked before, keep faith with yourself and do your best. Now "*au revoir*," and good luck.

To Those About to Enter the Dental School

By F. BOCQUET BULL, L.D.S., M.R.C.S., L.R.C.P.

A WORD of welcome on behalf of the school and hospital to all new dental students. In no former year has there been such keen competition for admission to the school, and you are to be congratulated that by your merits you have now become students at one of the most famous schools in the world.

This Hospital is a great public institution that has stood in high repute for many generations. This reputation has been earned for the Hospital by all who have been or are associated with it. Not only are you able to play your part in this connection, but it is up to you as a member of this institution to do so.

Your earlier years will be associated with such subjects as Chemistry, Physics, Biology, Anatomy, Physiology and Dental Mechanics and Prosthetics, and, with perhaps a slight exception in the last subject, you will not come into actual contact with patients until the years of clinical study. This is where it lies in your power to help to keep the reputation of the Hospital at its present high level. Remember that quality is more important than quantity regarding your actual work, as the standard that you set yourself while at the Hospital is the standard that you will probably carry through your working life. Be courteous and kind to your patients, and, above all, be punctual in keeping your appointments with them.

It is fitting here perhaps for me to offer one or two words of advice which should be advantageous to you. There are in existence a number of Prize Examinations held yearly for which you may enter. Now the winning of such a prize is, of course, a valuable thing in itself, but of equal, if not of greater, value in the long run is the experience gained during such an examination. Therefore enter for these examinations apart from any consideration as to whether you have a chance of winning a prize.

Another point to which I would draw your attention bears on the manner in which you should acquire your knowledge. All the teaching in the world will not make more than an average individual of you. You must go out of your way to acquire that extra which makes the difference between the average and the excellent. No one can do this for you ; it depends entirely on your own initiative. One more word of advice —cultivate your power of observation. Probably at no other place will you have a greater opportunity to do so. If your power of observation is keen, then, not only will you obtain extra knowledge by your observation, but you will be able to make better use of the teaching that is imparted to you.

The actual courses of study will be found in full detail in the Prospectus of the School, which, if you have not a copy already, may be obtained at the Medical School Office. All students should make themselves acquainted with the contents of the prospectus, for therein are to be found the regulations respecting students with which students should be familiar, and other useful information, the possession of which may save much time and trouble.

If ever in doubt about anything connected with your programme of studies obtain advice from the Dean, sub-Dean or other officials at the Medical School Office. For your own benefit, in more ways than one, you should study diligently and work hard ; at the same time remembering to keep a proper balance between your work and recreation. Failure to maintain this balance means that your work will suffer either, firstly, by too much time being devoted to recreation ; or, secondly, by too little time in the same direction causing you to become stale.

If you carry out these precepts then your progress should be in all ways satisfactory, but if at any time you feel that such is not the case, then seek the advice of your teachers, advice which will be willingly and freely given.

To Those Entering the Nursing School

THE Preliminary Training School is once more changing its home, so to those entering the October school, we say "Welcome to Holmesdale." This fine red-brick house, with its extensive grounds, is in Nutfield village, three miles from Redhill. It was given to Guy's in 1945 by the generosity of Mr. W. H. McAlpine and Mr. S. B. Askew, two of our Governors. It has just been derequisitioned by the Army authorities and has been offered as temporary quarters for the Preliminary Training School. We wish you, the first entrants, a happy three months there preparing for your work in the wards after Christmas. May you work hard at your studies and catch something of the spirit of Guy's even though 25 miles away from the parent hospital. The day which you are to spend at Guy's each week should give you a glimpse of what you are coming to—a life of hard but satisfying work for those who have chosen a career with a predominantly human interest.

Now a word of welcome to those who have recently entered the wards and signed their agreement to take the Guy's training. The "Block System" of training is at last to be started this autumn. The present Preliminary Training School classrooms will be free when Holmesdale is opened. Guy's will again be a pioneer among the large training schools in introducing a system of training more in line with modern educational ideals and resembling very nearly the scheme recommended by the Nursing Reconstruction Committee, under the chairmanship of Lord Horder. This is a real step forward in nursing education, and one which was first discussed by the Education Committee of the Guy's Hospital Nursing School in 1938–39. Sir Herbert Eason and Miss MacManus recommended the scheme to the Governors, but it has only just become possible for the Governors to give the word "Go."

We hope the periods of study away from the wards each year will relieve the strain from both sisters and nurses and will make the study and practice of nursing more enjoyable and profitable. The social side of the nurse's life should also benefit As the patient requires a 24 hours' nursing service there must always be difficulties on this score, but the added facilities for study provided by the "Block System" should make it possible for nurses to enter more fully into the general community life of the hospital.

The introduction of the scheme involves reorganisation of periods of night and day duty, holidays, and ward time-tables as well as transfers from the units still at Orpington and Pembury.

Nurses now in the early days of training to whom this note of welcome is addressed, will be the first to benefit (we hope) by the new arrangement. During the transition period we ask for the co-operation of you all in making the venture a success and a stepping-stone to further advance.

"*Dare quam accipere.*" H. M. G.

Student Health Service

A STUDENT Health Service was originally started at Guy's before the war. It was necessarily interrupted during the war years, but it is now again in full operation.

The object of the scheme is primarily to maintain the health of students and to use the resources of the hospital to the best advantage, both in the early treatment of disease and in the remedy of existing defects.

The following are the present arrangements:—

(1) All students are medically examined during their first year in the School and an X-ray examination is made of the chest. Should any condition be found for which treatment is desirable, the student is referred to the department of the hospital where this can best be carried out, or arrangements are made for this student to be seen again as should be necessary.

(2) Further X-ray examinations are carried out every year, or at more frequent intervals where this is considered advisable in individual cases.

(3) Before entering the wards, students are Schick-tested and those who are not immune to diphtheria are given protective inoculation. In addition a Mantoux test is carried out. If this indicates susceptibility to tuberculous infection, further tests are carried out and X-ray examinations arranged at intervals not exceeding six months.

(4) A special Out-Patient Clinic is held every Saturday morning at 10.30 a.m. Any student who desires medical advice may attend. He will be seen by one of the medical registrars and, should it be necessary, he will be referred for the further opinion of a member of the Visiting Staff.

(5) Confidential records are kept of these examinations and also of any illnesses treated at Guy's or elsewhere.

It will be appreciated that the number of routine examinations involved each year in carrying out this programme is very large. Thus nearly a thousand X-ray examinations have been made on behalf of the Service between March and September of this year and over 300 medical examinations and consultations held. All examinations are made by appointment so that there shall be as little waiting as possible; lists of appointments are posted on the special notice board at the entrance to the Medical School, in the Dental School and in the College. In order that the Service may work smoothly and to the best advantage of those taking part, it is important that appointments should be kept. Where the appointment is at an unsuitable time, the secretary to the Health Service will be pleased to change it if adequate notice be given.

It is only if full use of the Service be made by everyone that the Service can really be a success. During the past year a great deal has been achieved; advice has been given to a large number of students and cases of tuberculosis have been detected in an early and favourable stage. It is hoped that all students will take part in the Service to ensure the best preservation of their own health and that of the community to which they belong.

W. N. MANN

Guy's Hospital Clubs' Union

THE handbook of the Clubs' Union, in which its many activities are recorded, is available in the Medical School Office. It is therefore proposed to give only a brief note here.

By payment of one subscription a student becomes a member of all the clubs and societies affiliated to the Clubs' Union. He is enabled to use the premises of the Students' Club at Guy's and the 15-acre ground at Honor Oak Park. Moreover, he becomes entitled to a copy of the Guy's Hospital *Gazette* without further charge. From the notes on each society it will be seen that facilities for a very large number of sports and other interests are provided.

The premises of the Students' Club have been reduced unfortunately by the damage sustained from the bombing of the College. However, the old "Spit" and the Pavey gymnasium are being opened shortly as additional dining rooms and the lunch-time congestion in the Restaurant will be much relieved. It is hoped that the time will be not far distant when a new College can be built, but it will be understood that no date can yet be foretold. A new gymnasium and squash courts are available at the Hospital and the ground and quarters at Honor Oak Park are especially good.

A very important change in the rules of the Clubs' Union has just beem made. This concerns the constitution and has for some time been under consideration. It is as follows:—

The affairs of the Union shall be managed by a Council of twenty-five. Of these six shall be members of the Hospital and School Staff, to be elected annually at a School Council; seven shall be members of the Hospital and School Junior Staff, to be elected annually by a meeting of the Junior Staff Committee; and twelve representatives of the Students, to be elected annually in October in the following manner:—

(i) Two to be appointed by the Committee of the Students' Club.

(ii) The Hon. Secretary of the Rugby Football Club.

(iii) The Hon. Secretary of the Students' Union.

(iv) Four to be elected from among the Hon. Secretaries of the other Athletic Clubs. The Secretary of the Rugby Football Club shall convene a meeting of Secretaries of the Athletic Clubs who shall form an electoral body.

(v) The Hon. Secretary of the Dental Society.

(vi) Three to be elected from among the Hon. Secretaries of the other Non-Athletic Clubs. The Secretary of the Dental Society shall convene a meeting of Secretaries of Non-Athletic Clubs who shall form an electoral body.

The Clubs' Union Council acts as trustee for members' subscriptions and allots funds in fair proportion to each constituent club.

We do advise all students to read the Handbook and in order fully to partake of the life of the Hospital to join the Clubs' Union.

Below is a list of constituent clubs with dates of foundation :—

AFFILIATED.

Athletic Club	1860	Hockey Club	
Cricket Club		Lawn Tennis Club	1888
Debating Society	1892	Pavey Gymnasium	
Dental Society	1894	Fencing Club	
Rugby Football Club	1843	Physical Society	1830
Association Football Club	1882	Rifle Club	1883
Golf Society	1903	Boat Club	
Sailing Club			
Students' Club	1882		
Swimming Club			
Boxing Club			
Theatre Club	1945		
Music Club			
Students' Union	1941		

NON-AFFILIATED.

Christian Union	1847	Musical and Operatic Society	
Physiological Society			

RAYMOND HINDE,
Hon. Secretary,
Club's Union Council.

BOAT CLUB

As there are no facilities for coaching beginners, the Boat Club must of necessity be composed of men with previous rowing experience.

Thames Rowing Club very kindly allow the Club to use their boathouse at Putney, from which an eight goes out almost every week of the year, and spare men can usually find a place in one of the Thames' crews.

The usual regattas for which a crew is entered are the Head of the River race in March ; Putney and Fulham regatta in May ; United Hospitals' regatta in June ; and any other races that can be arranged.

The annual general meeting will be held on Wednesday, 16th October, at 1 p.m. in Classroom I, to which any prospective new members are invited to attend.

Hon. Secretary,
D. G. BRETT,
Dental School.

BOXING CLUB

The Boxing Club has come to life again after being rather dormant during the war years. Last season was particularly successful, in spite of the fact that the club had lost several of its former "stars." The three inter-club matches were all keenly contested. We beat Cambridge University (4—3), tied with the Polytechnic B.C. (3—3), and lost by the odd contest of nine at Oxford. Several Guy's boxers were chosen to represent the English Universities against the Scottish Universities, but unfortunately this match was cancelled, as was the Inter-Hospital Competition.

It is certain that the Boxing Club will be even busier this season and we hope to see the names of many newcomers on the list in the colonnade, and to see them in the Gymnasium. Last season's success was largely due to new members and we hope to be able to say the same again in the future.

S. F. A. W.

CHRISTIAN UNION

Originally formed in 1849, the Guy's Hospital Christian Union exists to unite and help those members of the hospital, of all denominations, who trust in Jesus Christ, and to put His claims before those who have no such faith. Its members are also kept informed of activities of the London Inter-Faculty Christian Union.

All are welcome to our meetings, held by kind permission of the Chaplain in the Chapel or the Crypt under the Chapel. The chief meetings are at 5 p.m. each Thursday in the Crypt for study of the Bible, a service at 9.30 p.m. each Sunday in the Chapel, and meetings for prayer at various times during

the week. Times and places are subject to alteration according to notices posted on the Christian Union notice-board in the Colonnade, where further details of our activities will also be found.

D. C. TURK.

CRICKET CLUB

A hearty welcome is extended to all cricketers joining the Hospital, which has just completed its 1946 cricket season. It is not intended here to give an account of the results of the Club's efforts but it may be mentioned that the Hospitals' Cricket Cup returned to Guy's and that a touring side visited Devon where the leading clubs were played.

During the 1947 season it is intended to field two sides and to repeat the visit to Devon, while once again a prominent feature will be the playing of the Cup Competition in which every effort will be made to retain the trophy.

Success will be dependant, in a large measure, on the keen support accorded to the club by the Hospital's cricketers, so we urge them to make full use of the excellent facilities provided at Honor Oak Park and not to hesitate to come forward should they wish to play.

J. D. W.

DEBATING SOCIETY

The Debating Society of Guy's Hospital hopes to continue its activities during the coming winter, and we cannot stress too much the fact that any success which it may hope to achieve, depends on the interest which members of the Hospital take in it.

The Annual General Meeting of the Society for the election of officers will be held on Oct. 15th at 4.30 p.m. A notice will be put up later on to give more information about it.

Last year was a fairly successful one and after a late start we held in all four Debates.

Let this year, the second since the Society's revival, be even more successful.

C. J. EARL,
D. C. DEUCHAR,
Hon. Secs.

FENCING CLUB

This year the Club starts the season with a good number of old members and a team with a fair amount of experience. New members are urgently required so that the excellent progress of last year shall be maintained. Novices are especially welcome.

Tuition is in the very capable hands of Colour-Sergeant L. V. Clarke (late of the Royal Marines), who has a wide experience of fencing, including a place in the pre-war Olympic team.

The first team has a good list of fixtures, some of them involving all three weapons. In view of the keenness shown last season a second foil team has been formed, with an extensive fixture list. Should this keenness remain and fixtures be forthcoming, there is no reason why a third team should not be formed.

However, a word of warning to beginners: fencing is an art requiring a good deal of perseverance, especially in the early lessons. Practices will be held twice a week and those interested should watch the notice board in the Colonnade for future announcements.

N. H. PORTER, Captain.
G. F. CONRAN, Secretary.

ASSOCIATION FOOTBALL CLUB

The Association Football Club at Guy's was established in 1882. So great was the enthusiasm of the team that in 1883 Guy's initiated the institution of the United Hospitals' Association F.C., and subsequently, in 1885, became the first holders of the Inter-Hospitals Cup. From that date the Inter-Hospitals Cup Competition has been held on fifty-one occasions, Guy's being the winners twenty times.

In order to uphold this fine record we shall need many new players in the coming season. It is absolutely imperative that a strong and enthusiastic 2nd XI should be organised, so as to provide a source of replacements for the many fine players that will be leaving the Hospital team this year.

Our fixtures this season promise to be some of the best in the history of the club. They include the University teams of Birmingham, Reading and Southampton, as well as such strong Service teams as the Royal Marines (Chatham) and the R.N.E.C., Greenwich. In all some thirty-five games have been arranged.

In conclusion, on behalf of our captain, H. R. C. Riches, and myself, I should like to extend a hearty welcome to all new Soccer players entering the Medical and Dental Schools this October.

E. M. NEWTON,
Hon. Sec.

RUGBY FOOTBALL CLUB

This club, since its foundation over a century ago, has grown to enjoy a first-class reputation, and many fine players and personalities have graduated from its ranks in the past. Not to them alone are we indebted for our position in the rugger world, but to the fine spirit with which the game has been played by all teams representing the Club. We are certain that in this our 103rd season, the same will hold good and to those newcomers intending to join us, we extend a very hearty welcome.

Membership of the Clubs Union entitles anyone to the use of its Sports ground at Honor Oak Park, which is very conveniently situated, offering excellent facilities, and we hope everyone will take full advantage of them.

Fixtures have been arranged for five fifteens, but some difficulty has been experienced in ensuring a fair distribution of "Home" matches among these teams. To alleviate this to some extent, a pitch at Motspur Park will be available on certain dates during the season.

Lastly, we appeal to all to support the Club, either by playing or on the touch-line, and to the teams we wish a most successful season.

Any information required about the Club may be had from either Mr. G. Winston in the Library, or myself.

A. G. McCALLUM.
Hon. Sec.

HOCKEY CLUB

The activities of the Hockey Club have been rather curtailed during war-time. Before the war we ran four or five XI's,, but for the past five years only one XI has been fielded regularly every Saturday. A 2nd XI. was started again three seasons ago.

We had, however, some very good results during that time and a number of our players

have represented United Hospitals and London University sides.

We wish to bring Guy's Hockey Clubs up to full strength again in post-war seasons. For this reason a full and attractive fixture list for two XI's has been arranged and requests from many of our pre-war opponents will enable us to run other XI's in future if we receive sufficient support.

New players (irrespective of standard) are, therefore, very welcome, especially returned ex-service men who may have played in previous years. Those interested can add their names to the list on the Hockey board in the Colonnade or get in touch with I. Kelsey-Fry, the captain for the coming season, or myself.

J. B. HARRIS.
Hon. Sec.

LAWN TENNIS CLUB

The first post-war tennis season has been most successful, despite the unfavourable weather. The standard of the tennis team has been high and our fixture list has included many of the leading clubs in London. One fixture in particular which we were very glad to review was that with Professor Johnston's team whom we would like to thank for a very enjoyable afternoon.

Several of our members have played for the United Hospitals and London University teams. The Arbuthnot Lane-Washbourne Cup competition has been resumed and we have won the Inter-Hospital Cup, defeating St. Bartholomew's Hospital by 8 matches to 3 in the final.

I would like to thank Mr. Kirby who, despite labour shortages and adverse weather conditions, has maintained the grass courts at H.O.P. in excellent condition.

Labour permitting, three hard courts will be available at H.O.P. this winter. In order to maintain the high standard of the tennis team next season, it is to be hoped that students will use these courts as much as possible.

P. J. DWYER,
Hon. Sec.

MUSIC CLUB

The Club is continuing its activities this term after its highly successful first peace-time concert in June. It is intended to give another concert in December, part of which will be music from Handel's "Messiah," and lesser known Christmas carols. As there are vacancies in all parts it is hoped that all who are interested and would like to sing will come along—despite any views they may have of their own voice or ability. Mr. Noel Nickson has very kindly agreed to help us again this term. Rehearsal times are arranged to suit as many as possible and I should be grateful if all those interested will let me know their time tables as soon as they can.

There is a Chamber Music Group which meets from time to time and all instrumentalists are welcomed. They should get in touch with Mr. A. H. Stocker with a view to arranging further practices. The standard is unfortunately not very high and anybody with a little experience would be of great help.

Weekly Gramophone Concerts are given on Thursdays from 1—2 p.m. in the New Theatre. Everyone in the Hospital is warmly invited, including Nurses, Physiotherapeutists, Radiographers and Almoners. As these Concerts have been such a source of pleasure in the past, Mr. B. H. Bass is arranging an additional longer and more ambitious Concert to be held one week-day evening. Also the B.B.C. send us Complimentary Tickets for their studio concerts. These tickets are available from the Secretary.

It is hoped that all newcomers will make full use of these activities, and the Club's notice-board in the Colonnade and the entrance to the Medical School should be consulted for notices of Concert Programmes, Recitals, and times and place of rehearsals and tickets. Any further information can always be obtained from the Hon. Secretary or any member of the committee.

ROBERT TAYLER.
Hon. Sec.

PHYSIOLOGICAL SOCIETY

The late Professor Pembrey founded the Physiological Society in 1900, regarding it as a means whereby the student's interest in Physiology could be intensified, and an acquaintance could be made with public oratory and business procedure.

The Society is an autonomous body, financially independent and free from any external control. It is open to all Guy's students, and meetings are held throughout the winter and spring terms. Here, original papers of Physiological interest composed by students are presented, and many Guy's men make their first remarks in public during the animated discussion that invariably follows. The Pembrey Prize is awarded annually to the author of the most meritorious paper.

It has been impossible during the war to continue such social activities such as the annual dinner and the pre-meeting teas, and these cannot be resumed until the food situation improves. Meanwhile the annual subscription of 3s. 6d. is suspended.

The advantages of membership are that at these meetings the student is brought into contact with modern Physiological ideas presented in a very palatable form. The first meeting will be held during October and all prospective new members are invited to attend.

J. H. EVANS,
Hon. Sec.

SAILING CLUB

The achievements of the club during the war have been due to the efforts of a small band of keen sailing men, so freshmen with experience of yacht racing will receive a hearty welcome; the inexperienced, however, are not excluded, as it is usually possible to coach them by means of lectures or practical instruction.

Four Y.H. one design fourteen foot lug-sail dinghies are available for sailing at the war-time headquarters of the club at Hammersmith, with certain rules and regulations governing their use.

There are eight Y.R.A. fifteen foot sailing dinghies on order for the United Hospitals Sailing Club. It is hoped that these will arrive early next year.

The whole club will be moving down to Burnham-on-Crouch next year, where there will be greater sailing facilities.

Newcomers who are interested should watch the notice board in the colonnade or contact me.

D. J. MURCH,
Hon. Sec.

SQUASH RACQUETS CLUB

The Squash Club presents perhaps the most convenient facilities of any constituent club. Two excellent courts, built just before the war, stand behind the Nurses' home, in the Pavy Gymnasium. The court lights are now provided free, and a changing room with hot showers is always available. The courts must be booked in advance in a ledger *outside the Porters' Lodge in the College.*

This season a 1st team match has been arranged for every week, and, for the first time, a number of 2nd V matches are also being played. It is, therefore, important that all those interested should put their names on the squash ladder in the gallery of the court, and also take part in the trials and competitions.

It should be realised that any student who was in his school team should easily get a place in one of the Guy's teams, and even those who were not have a good chance.

P. S. CARTON-KELLY (Captain).
C. J. A. MENZIES (Hon. Sec.).

STUDENTS' UNION

The Students' Union aims first at representing the views and wishes of students on any matter, large or small, which may concern them; secondly, at promoting social and cultural activities not catered for by other constituents of the Clubs' Union. It also handles the various communications, appeals, invitations, etc., which are from time to time addressed to the students of this hospital. Its official journal is "Pulse."

All medical and dental students are entitled without subscription to benefit from the work of the Union and to participate in its activities. The representatives that they elect together form the Students' Union Council.

Last year, amongst other activities, several large and successful dances were organised; a number of talks by eminent men on artistic, literary, musical, and medical subjects were arranged; and various discussions took place. At the same time renewed efforts were made to represent more effectively the opinions and suggestions of *all* students on a variety of matters.

The Students' Union has slowly developed and expanded since its inception in 1941. Its future will depend on how many there are who consider its aims worth while and are prepared to undertake its work when called upon.

JOHN HOLDEN,
Hon. Secretary.

THEATRE CLUB

Last June the Theatre Club presented Terence Rattigan's Comedy, "French Without Tears," at six performances. Fifty pounds (the profits from this venture) have been sent to the Appeal Secretary for the formation of a Fund for re-equipping the ward with Wireless apparatus. We record here our gratitude for the generosity which made this possible.

Since January, 1945, Members of the Club have presented five full-length plays. The programmes record the names of over fifty persons who took part in these productions, besides an equal number who have given their services namelessly. This serves at once to illustrate the enthusiasm for amateur stage-craft which exists at Guy's, and to refute the fallacy, current among some, that the activities of the Theatre Club are confined to a small clique.

Recruitment must keep pace with manpower wastage. Next December it is hoped to present "Hay Fever"; notices have already appeared advertising the time and place of auditions. The response to such notices in the past has not been encouraging, perhaps because in the minds of those who would have come forward lurked the suspicion that their services might be rejected in *favour of those of less talented members of* the so-called "clique." We cannot too strongly deny the existence of any foundation for such a notion—the producer chooses his cast on individual merits, and anyone who has acting experience has a good chance of being chosen.

Suggestions for productions do not necessarily emanate from the Committee. Any member may produce a play provided he can satisfy the Committee that, with its help, there is a reasonable chance of success. Also the activities of the Club are not inevitably restricted to full-length plays, although full-scale productions of One-Act Plays are uneconomical.

Finally, a word to preclinical students. The foundations of the Theatre Club were entirely laid by members of the preclinical school. That most of these members have now passed into the clinical period is no reason to delay your own rise to stardom till you have done likewise.

J. G. STEBBING.

List of Entries

GUY'S HOSPITAL MEDICAL SCHOOL.

OCTOBER, 1946.

1st YEAR STUDENTS.

Name and School.

Ainsworth, V., Cotton College, Stoke-on-Trent.
Allday, R. K., King's College, Taunton.
Anderson, J. K., St. Lawrence College, Ramsgate.
Barker, S. S., Whitehaven County Secondary School.
Barker, V. C. J., Brentwood School.
Bateman, F. J., Alleyn's College, Dulwich.
Birch, E. W. G., Heath Grammar School, Halifax.
Brearley, L. H., Bec Secondary School, S.W.17
Brooks, N. C., Brentwood School.
Brotherhood, R. W., County School, Sutton.
Bullen, C. V., Dauntsey's School.
Burrell, B. T., King Edward VI School, Norwich.
Bush, D. S., Whitgift School.

Campbell, A., Rhodes University, S. Africa.
Carter, A. J., Woolwich Polytechnic.
Clapham, E. E., Grammar School, Dartford.
Clarke, T. A. P., Sherborne School.
Cottier, D. F., Felstead School.
Culverhouse, J. K. H., Victoria College, Jersey, C.I.

Dawson, E. C., Taunton School.
Duckworth, D. V., Bishop Cotton School, Simla.
Duke, H. P., Wallasey Grammar School.
Dummer, W. F., Margate College.
Dunbar, P. G., Bancroft's School, Woodford Green.

Emery, L. L., County School, Barry.
Evans, G., Hereford High School.

Green, D. J., Beccles County School.
Gurner, I. E., Chichester High School.

Hardiman, P. M., Harvey School, Folkestone.
Haydon, E. G., Truro School.
Higgins, B. K., St. Joseph's Academy, Blackheath.
Hunt, J. G. P., Bryanston School.

James, E. M., Cornwall College, Jamaica.
Jenkins, P. K., Magdalen College School, Brackley.
Jones, J. E., Cardigan County School.
Jordan, J. W., Grimes Tutorial College.

Kirkbride, J. W., Wellington College.

Large, A. V., Michlæhouse, Natal.
Lymbery, J. G., Alleyns School, Dulwich.

Matherson, W. A., Hurstpierpoint.
McGill, D. A. F., Minchenden Grammar School.
McKenzie, E. N., Natal University College.
MacMilian, I., Glasgow Academy.
Mallett, B. L., Colston's School, Bristol.
Mansbridge, H. St. J., Haileybury, Trinity College, Oxford.
Marin, G. A., Herne Bay College, Kent.
Moore, W. P. N., Downside School.
Murray, E. A., Lawrence Royal Military School, India.
Myer, F. G. M. G., Wellington College.

Pearson, J. M., Haileybury.
Prosser, D. J., John Ruskin Grammar School, Croydon.

Rawson, G. S., Bury High School.
Reeve, H. S., Alleyn's School, Dulwich.
Robinson, D. S., Ellesmere College.
Roper, F. E. N., Cornwall College, Jamaica.

Scott, A. J. R., Stowe School.
Scriven, J. E., St. George's College, Buenos Aires.
Shelley, R. C., Brentwood School.
Skinner, G. B., Tiffin Boys' School, Kingston.
Smith, A. J., St. Dunstan's College, S.E.6.
Smith, R. C., St. Lawrence College, Ramsgate.
Steele, F. L. D., King's School, Ely.
Stewart, R. M., Berkhamsted School.

Thomas, D. L. J., St. Edmund's, Canterbury.
Thomas, R. V. L., St. David's College, Lampeter.
Thorburn, T.A., Polytechnic, Penrith Grammar School.

Waller, D. J., Alleyn's Grammar School, Stevenage.
Warne, C. H. W., Michælhouse, Natal.

2nd YEAR STUDENTS MEDICAL.

Name and School.

Abdool-Raman, A. C. D., Royal College, Mauritius.
Amos, D. B., Bromley County School.

Bacon, K. S., Alleyn's College, Dulwich.
Bailey, J. H., Longton High School.
Baker, G. A. E., Wanstead County High School.
Bender, K. B., Queen's College, British Guiana
Bosher, S. K., Newbridge Secondary School.
Bowes, I. N., Epsom College.
Bromley, J.,

Clarke, J. A., Blackfriars School, Laxton.
Cooper, K. V., Wanstead County High School.
Covill, F. J., Maidstone Junior Technical School.
Davis, L. M., Cranleigh School.
Druitt, R. D. P., Epsom College.

Ernsting, J., Chislehurst & Sidcup County School.
Evans, J. H., Sevenoaks, School.
Faull, R. D., Bristol Grammar School.

Gazet, J. C., Alleyn's Grammar School.
Gold, H., Northern Polytechnic.

Hexter, H. G., City of London School.
Hoyle, H. V., Manchester University.

James, W. V., Southfield School, Oxford.
John, G. J., University College of Wales.
Johns, E. T., Brighton College.

Lansdown, P. F. P., Epsom College.
Lewis, W., Ystalyfera County School.
Lovell, D. T., Eltham College.

Karpusheff, G. M., St. Joseph's College, Hong Kong.
Kendall, J. C. C., Sherborne School.
Koblenzer, P. J., Eastbourne College.

Packmayr, J. N., Northern Polytechnic.
Paget, S. A. C., Newbridge Secondary School.

Rademan, P., Capetown University.
Ratcliffe, J. H., Oakmount Arnside, Oatlands, Harrogate.
Rees, J. E., Swansea Grammar School.
Rolls, E. J., St. Olave's Grammar School.

Steward, R. V., Denstone College.
Shaw, G. L., Nottingham High School.
Shepherd, R. J., Colwyn Bay Grammar School.
Sorefan, A. M., Mauritius.
Spooner, A. G., Royal Grammar School, High Wycombe.
Staple, P. H., Leighton Park School, Reading.

Tatford, E. P. W., Bedford School.
Thornton, J. A., St. John's School, Leatherhead.
Trenhaile, A., Queen Mary's College, London.

Whitaker, H. R., Grime's Tutorial College, Manchester.
Wilkinson, C. H., St. Albans School.
Wollner, L., Birmingham Central Technical College.
Woodford, J. F., Rossal School, Fleetwood.

Zorab, P. A., Cheltenham College.

CLINICAL PERIOD OF STUDY, OCTOBER, 1946.

Name and School.

Armstrong, J. G., Queen's College, Oxford.

Baxter, R., Gonville & Caius College, Cambridge.
Beard, R. G., Clare College, Cambridge.
Brookes, M., Brasenose College, Oxford.

Clapham, C. C., Christ's College, Cambridge.
Couch, L. G., University of Witwatersrand.
Crichton, R. C., Oriel College, Oxford.

Draper, J. W., Queen's College, Cambridge.

Gee, N., St. Catharine's College, Cambridge.

Holden, G., Clare College, Cambridge.
Hunter, M. J., St. John's College, Cambridge.

Ludwig, J., Canada and U.S.A.

Mackenzie, K. G. P., Jesus College, Cambridge.

Rayne, M., King's College, Cambridge.
Rees, V. E., University College, Cardiff.

Retief, F. W., University of Cape Town.
Robinson, K. F., Jesus College, Cambridge.

Soothill, J. F., Christ's College, Cambridge.

Vans Agnew, W., Pembroke College, Cambridge.

Watson, C. N., University College, Oxford.
White, R. H. R., Emmanuel College, Cambridge.

GUY'S HOSPITAL, DENTAL SCHOOL, OCTOBER, 1946.

PRE-MEDICAL STUDENTS.

Name and School.

Alsop, R. R., Cambridge County High School for Boys.

Baker, S. G., Borough Polytechnic.
Ballantyne, K., King's College School, London.
Brangwin, S. G., Manwood's School, Sandwich.
Brown, F. G., Tottenham County School.
Burke, P. T., St. Michael's College, Hitchin.

Carr, H. G., St. Albans School.
Carter, H., Roan School, Greenwich.
Chambers, K. S., Lower School of John Lyon, Harrow.
Cook, I. H., Whitgift School, Croydon.
Cossey, D. L., Slough Grammar School.

Davis, H. de V., Medway Technical College.

Ede, M. H., Plymouth College.

Flynn, W. D. P., Wimbledon College.

Gapper, A. G., Torquay Grammar School.

Hobbs, J. M., Epsom College.

Jackson, G. J., St. Paul's School, Hammersmith.
James, D. G., County School, Llandyssul.
James, H., Llandovery College.
Jones, R. B., County School, Llandyssul.

McCandlish, A. W., The College, Swindon.
Matthews, D. G., Caerphilly Boys' Grammar School.
Mayson, N. J., Haberdashers School.
Mitchell, S. F., St. John's College, N.4.
Mortimer, G. V., Southport College.

Neill, D. J., East Sheen County School.

Pickup, K. H., Bains's Grammar School.
Prentice, H. R., Epsom College.

Searle, E. G., Deacon's School, Peterborough.

Taylor, G. K., Ashton Grammar School.
Thomas, D. W., Plymouth College.
Tyrell, M. S., Dulwich College.

Warren, P. W. P., Bedford Modern School.
Westlake, A. V., Clapham Central School.
Whalley, R. B., Clitheroe Grammar School.
Willcox, G. F., Stationers Companys School.
Whitaker, A. R., Southgate County School.
Woods, A. E., Hertford Grammar School.

1st B.D.S. STUDENTS.

Name and School.

Bligh, A. J., Caterham School.

Danford, G. H., Brentwood School.
Darvell, J. A., Ratcliffe College.
Davis, G. A., Farnborough Grammar School.
Daw, P. D., Worthing High School.
Day, R. J. G., St. Albans School.

Earl, S. S. R., Christ College, Brecon.
Embleton-Smith, B. A., Westcliff High School

Hardy, D. K., St. Paul's School.

Jennings, A. G. P., King's College School, Wimbledon.
Jones, D. J. I., University College of Wales, Swansea.

Mepsted, J. A., Cranbrook School.

Price, N. E., Durban.

Riley, J. M., Brighton College.
Rusden, P. M., Winchester College.
Roth, F., Cooper's Company School.

Singer, I., Parmiter's Secondary School.
Stott, J., Drayron Manor County School.

Walby, J. C., Roborough, Eastbourne.
Whaites, W. C., Gt. Yarmouth Grammar School.
Wilder, M. L., Hackney Downs School.

1st YEAR (L.D.S.). STUDENTS.

Name and School.

Barker, J. D., Chislehurst & Sidcup County School.
Bathurst, M. E. S., Bradfield College.
Bjarnason, S. S., Akureyri and Reykjavik, Iceland.
Bret-Day, R. C., English School, Helipolis, Egypt.

Celestin, C. L., Royal College of Mauritius.

Dawson-Squibb, L., Michælhouse, Natal.

Flynn, J. R., Christian Brothers College.

Gardener, P. A., Chatham House County School.
George, W. J., Chelsea Polytechnic.
Gibb, G. D., St. Helen's College, Southsea.
Grant, J. M. D., Eastbourne College.
Griffith, D. M., University College School, Hampstead.

Legg,, W. H., Bootham School, York.
Lewis, R. R., Swansea Technical College.

Porter,, W., Regent Street Polytechnic.

Rice, V. G., Brentwood School.

Skaith, R., Wintringham Secondary School.
Smith, T. M., Bedford School.

2nd B.D.S. STUDENTS.

Name and School.

Burnapp, D. R., Whitgift Middle School.

Garland, W. H., Wellingborough School.
Gerrard, P. E., Hampton Grammar School.

Levison, H., Southend-on-Sea, High School for Boys.
Lyons, D. M. J., Taunton School.

Muncey, K. F. C., St. Paul's School, Hammersmith.

Powell, H. W., Cooper's Company School.

Reviews

Introduction to Clinical Neurology. By GORDON HOLMES, F.R.S., M.D., F.R.C.P. Livingstone. Price 12*s.* 6*d.*

THIS is an excellent book. It is an accurate and penetrating analysis of the symptomatology of organic nervous lesions, and is written in an easy and direct style. Moreover, it is simply and ably illustrated with line diagrams which can be truly said to amplify and clarify the text.

This is a book to be read early by the student, preferably during the preclinical appointment, and it is also of value to post-graduates, not the least those contemplating higher exams. It stands in line with Walshe, and is in many ways complementary to the latter. It is to be recommended without reserve to all those interested in Nervous Diseases.

C. L. J.

Practical Anæsthetics for Students and Practitioners. By J. ROSS MACKENZIE, M.D., D.A. 2nd Edition. Baillière, Tindall and Cox. *Price* 10*s.* 6*d.*

AS the Author states in his preface, this book is intended as a useful guide for students, general practitioners and the occasional anæsthetist. It gives a clear and concise review of present day anæsthesia from the practical aspect, for the ordinary type of case which they are liable to meet, without attempting to deal with the more complicated and difficult techniques in detail.

The approach and general layout of the subject matter is simple and straightforward, and the chapters dealing with pre-operative preparation and post-operative sequelæ of particular value to all. There are 71 useful illustrations.

P. J. H.

The Theory and Practice of Nursing. By M. A. GULLAN. 5th Edition. H. K. Lewis & Co., Ltd. Price 12*s.* 6*d.*

A NEW edition of this practical nursing book is welcome at this time of general shortage of such books. A useful section has been added to the chapter on Administration of Drugs which includes Sulphonamides and Penicillin. The book seeks to present nursing methods associated with their underlying principles rather than presenting them as mechanical performances and as such is a useful addition to the nurse's library.

E. N. S.

Venereal Diseases in General Practice. By SVEND LOMHOLT, M.D. (Copenhagen), O.B.E. 2nd Edition. H. K. Lewis & Co., Ltd. *Price* 25*s.*

THIS is the first English edition of a text book which has been generally used in Scandinavian countries and reached its third edition in 1945. It is difficult to review a book which was written before the war but delayed in publication by the German occupation of Denmark; the clinical aspects of the diseases have not greatly changed in the subsequent years, but the advances in treatments render much of the text obsolete. This criticism is to some extent overcome by the addition of a supplement dealing with modern treatments including Penicillin, Arsenoxide, Sulphathiazole and Sulphadiazine. We differ in certain aspects of the treatment advocated: *10 grammes of Sulphathiazole daily (p. 224) is not necessary for the cure* of gonorrhœa and 0.06 gm. of arsenoxide is not experimentally equivalent to 0.45 gm. Neoarsphenamine—0.045 gm. stated is presumably a misprint. (p. 220). In the present changing schemes of treatment it must be admitted that Venereologists are experimenting in an attempt to find an adequate and improved method of treating thsese diseases, especially syphilis; the policy of relegating treatment to a supplement can be advocated for more general adoption until the outcome of these experiments are proved. It is unlikely that the knowledge of the clinical side of these diseases will greatly change and frequent revision of the text could thereby be avoided whilst ensuring clarity of description for the student.

The work suffers from ambiguity as a result of the author's attempt to revise and present the text in English which to him is a foreign tongue; it would have been better if Professor Lomholt had enlisted the help of an English clinician in clarifying certain statements. This opinion applies particularly to the section on gonorrhœa.

partly perhaps on account of the author's less close contact with this branch of the subject. The reader gains the impression that many of the opinions are the result of information gained from published work for they do not carry the conviction or continuity of personal views expressed in earlier sections of the book.

An unconventional and attractive cover with a quality of paper seldom found in recent English publications are notable features of this book. The illustrations are numerous and excellent and the shades of colour give a life-like picture of the lesions which are so ably described. I have never seen better colour plates and, if for no other reason, this book should be seen by every student. The section on Syphilis makes easy reading but undue space is allocated to the skin lesions, perhaps a valuable and in any case an understandable failing in view of Professor Lomholt's speciality. In the section on Gonorrhœa much of the detail of instrumentation and abortive treatment could have been eliminated in view of recent developments in treatment.

We welcome this book to the English series available on venereal diseases. With modifications in production and careful revision subsequent editions should win for it a high place in teaching.

D. E.

Food and Nutrition. The Physiological Bases of Human Nutrition. By E. W. H. CRUICKSHANK. 1st Edition. E. & S. Livingstone. *Price* 16*s.*

THE Professor of Physiology at Aberdeen has written a most interesting book. He specialises in a study of the problem of properly feeding all mankind, and has much to say to that end about the lessons of two wars and of the International Food and Agriculture Organisation, newly created. The book contains many useful and some little-known facts, as well as tables and figures most valuable for those interested in human (especially British and American) diets and in the history, preparation, and properties of the chief foods (including vitamins). Each chapter contains a bibliography. The book's format is impeccable. Second-year and later students, doctors and scientists will certainly value this work.

G. A. D. H.

Hospital Information, etc.

Notices

GUY'S HOSPITAL DENTAL SOCIETY DANCE.

The Committee regret to announce that owing to very difficult circumstances, Ted Heath and his band will not be available. They are glad, however, to say that the services of the Squadronnaires have been obtained instead.

Tickets (one guinea each) are now available from the Hon. Dance Secs.

C. B. SMITH.
G. A. KERR.

Pass List

CONJOINT BOARD, L.R.C.P., M.R.C.S.
September, 1946.

Chemistry.

A. I. Fram
A. N. Du Plessis
T. F. Lougher

Physics.

K. L. Chapman
G. V. Crine
A. N. Du Plessis
N. I. Lewis
M. J. March
F. R. B. Mathias
R. E. W. Pearce
P. Readings
G. S. Rose
R. L. G. Thornton
D. R. Whittington

Elementary Biology.

M. F. Ashby
K. L. Chapman
J. G. G. Dixon
A. I. Fram
H. E. H. Gillett
P. D. V. Harrett
D. London
T. F. Lougher
M. J. March
M. J. Quelch
P. J. Saville
J. J. F. Staub
A. G. Hitchcock
H. C. Hole
J. G. Levenson
J. S. Tisdall
G. M. J. Williams

CONJOINT BOARD.
FIRST EXAMINATION.
September, 1946.

Anatomy.

W. I. Abell
J. L. Harrington
E. M. Hume
G. A. Lawrence
M. Lewis
J. B. Parsons
A. R. Phillips
D. J. R. Snow

Physiology

A. P. T. Van Hamel
E. M. Hume
G. A. Lawrence
D. H. Le Clus
M. Lewis
A. R. Phillips
D. J. R. Snow

Pharmacology.

A. C. Bojé
P. O. G. Butler
J. M. Frisch
J. K. G. Grieves
A. Southwell

UNIVERSITY OF LONDON.
GENERAL SECOND EXAMINATION FOR MEDICAL DEGREES.
September, 1946.

J. H. McL. Buckley
B. Hartley
M. Mason
D. S. Noble
J. A. Payne

UNIVERSITY OF LONDON.
M.Sc. Physiology.
July, 1946.

E. O. Höhn.

UNIVERSITY OF LONDON.

SECOND EXAMINATION IN DENTAL SURGERY.

PART I.

July, 1946.

W. J. Bailey	P. B. Morris
R. McK. Carson	T. C. J. Price
J. D. Derry	A. A. Robinson
H. E. Dyer	A. H. R. Rowe
J. C. Farrow	C. B. H. Watson
N. R. Howells	J. G. Whitelegg
J. H. Keeling	

The following students are credited with Anatomy and Physiology :—

D. R. Boswell	M. Kaye
B. G. E. Donner	M. M. Keen
A. L. Giulianotti	P. J. A. Lawrence
P. Glazebrook	L. A. Rees
P. T. Grimer	J. D. R. Shaw

The following student is credited with Prosthetic Dentistry including Metallurgy :—
T. K. Walker

UNIVERSITY OF LONDON.

SECOND EXAMINATION IN DENTAL SURGERY.

PART II.

July, 1946.

J. L. Attenborough	*R. A. J. Mayhew
R. A. Dean	*J. D. Morgan
C. N. Furnivall	L. G. Richards
J. B. Harris	L. A. Rosen
S. P. Johns	P. H. Smith
A. Levy	*W. J. Tulley

* Awarded a mark of distinction.

THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.

July, 1946.

Honours.

S. J. Bell — J. S. Rose
B. M. Bilton

Distinguished in Dental Surgery, Operative Dental Surgery.

Pass.

S. F. Lamb	A. Rooms
R. A. Morsman	P. G. Shingler
A. K. Parsonage	

Supplementary Pass List.

The following Student has passed in Group I :—

A. Stone

ROYAL COLLEGE OF SURGEONS.

L.D.S.

FIRST AND SECOND PROFESSIONAL EXAMINATION.

September, 1946.

Dental Metallurgy.

W. A. B. Brown	G. F. Thompson
L. P. Frank	R. V. Warren
E. D. Morgan	J. L. Wynne
W. M. Sheeran.	

Dental Mechanics.

D. G. Bunker	B. S. Saunders
E. J. Deutsch	R. E. B. Turner
N. E. McIntyre	S. L. Woolgar

Anatomy and Physiology.

E. J. Annen	A. H. Stocker
G. D. Richards	T. K. Walker
M. J. Smallcombe	

Special Anatomy and Physiology.

E. J. Deutsch	H. L. Lefcovitch
D. J. W. Foster	D. F. Waller
J. K. Keen	

Papers by Guy's Men

Bradley, W. H. Recent trends in the incidence of infective fevers. *Practitioner*, 1946, **157**, 161.

Conybeare, E. T. Smallpox in the vaccinated. *Ibid.*, 191.

Warner, E. C. Asthma. *Ibid.*, 221.

Wigginton, D. J. A case of Costen's syndrome. *Brit. Med. J.*, 1946, **81**, 153.

Bradley, W. H. Homologous serum jaundice. *Proc. Roy. Soc. Med.*, 1945–6, **39**, 649.

Fourman, P., and Others. The fæces in sprue. *Brit. Med. J.*, 1946, ii, 418.

Cathie, I. A. B. Blood-groups in bone marrow. *Lancet*, 1946, ii, 418.

Maizels, Montague. Empirical tests of liver function. *Lancet*, 1946, ii, 451.

Vine, R. S. A remarkable case of mediastinal neoplasm. *Jour. R.A.M.C.*, 1946, **87**, 87.

Macintosh, R. R., and Another. Recent advances in anæsthetics. *Practitioner*, 1946, **157**, 303.

Appointments

A. J. Gibbings, L.D.S., has been elected Dental Member of the Medical Council of Southern Rhodesia.

Change of Address

H. Carlile Sturdy, M.D., Linsey Cottage, 11, Tennyson Road, Bognor Regis.

H. S. M. Crabb, B.D.S., Yew Tree Cottage, W. Overton, nr. Marlborough, Wilts.

R. W. B. Ellis, O.B.E., F.R.C.P., University Dept. of Child Life and Health, 19, Chalmers Street, Edinburgh.

Miss Thelma Jones, Royal National Orthopædic Hospital, Brockley Rise, Stanmore.

H. G. Ryder, L.D.S., R.C.S., Aldreth, Stonehouse, Glos.

S. J. Wheeler, Retired Surg.-Cmdr., R.N., Walton Court, Old Stoke Road, Aylesbury, Bucks.

Marriages

BREWIN—RICHARDSON.—On October 5th, 1946, at St. John's, Redhill, Thurstan B. Brewin to Doreen R. Richardson.

WHEATLEY—CLOUGH.—On August 31st, 1946, at the Baptist Tabernacle, Tunbridge Wells, Anthony J. L. Wheatley, L.D.S., to Margaret A. Clough.

Births

CROSS.—On Sept. 21st, 1946, at Nuffield House, Guy's Hospital, to Mary, wife of Dr. W. George Cross—a son.

HAWKINS.—On October 1st, 1946, at the Queen Elizabeth Hospital, Birmingham, to Susan (née Fantes), wife of Dr. Clifford Hawkins—a son.

SWANN.—On Sept. 29th, 1946, to Mair Christine (née Elsom), wife of Peter (G. F.) Swann—a daughter (a sister for Mark).

Deaths

BRUCE.—On Sept. 23rd, 1946, Robert Stephen Bruce, L.D.S., R.C.S., aged 36, of 175, Kidmore Road, Caversham, Reading.

ESTMENT.—On Sept. 5th, 1946, at East London, S. Africa, Vivian Russell Estment, L.D.S., R.C.S., aged fifty-one.

EDS. {R.T.H. D.H.F.

GUY'S HOSPITAL GAZETTE

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PASSIM

WE are pleased to be able to announce that three more appointments to the Honorary Staff have been made. Dr. C. G. Baker, who becomes an Assistant Physician, needs no introduction. He will be remembered as a medical registrar and, in nineteen thirty-four, as editor of this journal. Since then he has been at Selly Oak Hospital, Birmingham, and during the war serving in the Army. We are delighted to welcome him back. Mr. Guy Blackburn, the new Assistant Surgeon, comes from Bart's. Although he brings new blood into our veins it is compatible and well-matched, for not only is St. Bartholomew's the mother of all the hospitals of England but in the standing committee of the three hospitals she maintains to this day her especial link with ourselves and our own progenitor, St. Thomas's. Mr. Blackburn's appointment is as happy a one for us as we hope it will be for him. He will, of course, be expected to accept the Guy's version of the story of Percival Pott and his fracture. Dr. E. J. Crisp is taking charge of the Physiotherapy department, whose work is becoming of increasing importance.

A milestone has been reached in our history, a department of surgery having been created. This, we understand, in no way replaces our traditional system of surgical teaching; rather is it complementary and designed to fill in the gaps which that highly valued and well-tried method must, of its nature, leave. It goes further and yet not as far as the professionial units of some of the sister teaching hospitals, being less isolated and academic, more practical but of wider scope. Doubtless, other departments will be founded in the course of time, enriching the Guy's system of clinical instruction without transgressing its fundamental principles.

Mr. Atkins' appointment as the first Director is an augury that the new venture will yield ample dividends and in offering our congratulations we wish both him and the Surgical Department success eagerly awaited and surely promised. A departmental notice appears on another page.

CROSSING Great Maze Pond on our way to the College we met, the other day, an old contemporary. Greetings over, we asked was he demobilised? He was. What was he going to do? He hoped to come back to the Hospital for three months. And then? General practice, was the reply. We smiled politely at what we took to be his humour and repeated the question. His answer was the same. Once more we put it, this time not without asperity. It was true and he was serious; he was to be a general practitioner.

Now, this we tell you because it is in the realms of the phenomena. The procession of ex-servicemen who have come back to the hospital in the last two years have all been moved to have a common future. Physician, surgeon, obstetrician, physiotherapist, psychiatrist, one even a venereologist; every man a specialist. All with the same purpose; Membership on Fellowship, diploma of this or diploma of that. Anything rather than be a G.P.

Such is the position to-day and it is a very serious one. W. S. Gilbert knew of this ludicrous situation; his Grand Inquisitor tells of the king who "to the top of every tree promoted everybody." Ere long he discovers the truth that "when everybody's somebody, then no one's anybody."

There are several factors at work which are influencing the mind of the young doctor.

If he served in the army or air force as an ordinary general duty officer, or in the navy as a sea-going doctor, he found that he was required, save in the circumstances of emergency, to refer all but the most trivial of his cases to a hospital or a medical

formation. In his charge there thus remained patients with the common cold, gripes in the tummy or a corn on the toe. And their treatment was what might well be prescribed by the man in the chemist's shop or the chiropodist. Lest the admirals and generals who may be reading this are about to curse with choler or manhandle their moustaches, we say at once that we entirely understand that the duties of war made inevitable this state of affairs and that they did require a doctor to make the diagnosis before deciding which cases be kept and which be sent to hospital. Moreover, the effect on morale of the presence of a doctor in a fighting unit is too well-known to need defence.

But returning to civil life, the doctor has decided that he did not spend six years in qualifying solely to maintain the morale of potential patients merely by his presence among them. He wants to take part in curative medicine and asks himself whether the general practice of the future will allow him to do so. He knows that up to now, given the right practice, it does so but of the future he is less than certain. Casting his mind back to service days he remembers that he was a member of a hierarchy; and a lowly member, too. There were consultants, specialists and just medical officers; brass-hats, gold braid and red tabs. He has not forgotten that doctors remained colleagues not because of but in spite of their being graded like eggs or milk and he often envied the chaplains of the Royal Navy who bore no rank upon their sleeves.

These impressions of the years are indelible. They may have given rise to false premises, but from these is argued a new attitude of mind, and the man who before the war wanted to enter general practice is dissuaded from so doing because he believes that the new health service may erect a barrier between consultant and general practitioner whose difference in status will damage their relations as colleagues. On the other hand, if the disadvantages of an organised system were overcome in war, they will be overcome the readier in peace, but it might be observed that comradeship in medicine is less a tie than the brotherhood of the Bar and may not stand the strain as well.

This then is the first reason for the glut of embryo specialists. But there are others.

So uncertain is the future that a man willing and wanting to be a G.P. finds it hard to acquire, by borrowing, the capital needed not only for the practice but for a house and a car. Government compensation is being arranged in such a way that the risk is by no means negligible.

Then there is no means provided for a man to learn of the work or attractions of general practice, either as a student or afterwards, unless he do a locum tenens. It would be no bad thing if every teaching hospital had a general practitioner on its staff who might not only address medical students on appropriate subjects but possibly give some sort of practical instruction in, say, the Front Surgery. Probably best of all, would be a return to the apprenticeship system for by that means would be taught not only the technicalities of practice but also the art of dealing with patients as patients and in their own homes.

It is customary to hear said that the position will be resolved by large numbers of the intending specialists being forced into general practice by one reason or another preventing the gain of their goal. If that is the way to recruit G.P's. it is a poor one, for they will be but a body of disappointed and frustrated men.

To us it seems that the life of general practice must be explained clearly and frequently by the general practitioners themselves, that many may be led to look back over their lives maintaining that they would not have changed their calling for the "humbug of the Harleyans or the wiles of the Wimpolians."

THE work of the special departments at Guy's is too little known.

We are therefore glad to be able to tell our readers that Mr. Frank Law, as official delegate for this country, attended the fiftieth anniversary meeting of the Société Belge d'Ophthalmologie held in Brussels on September 28th and 29th. He read a paper entitled "L'ophthalmologie pendant la Guerre" which was very well received. The Society conferred upon him an honorary membership and awarded him the Van Duyse medical medal.

We congratulate Mr. Law on thus bringing honour to himself and to the hospital.

WITH great pleasure, we have noticed Mr. Davies-Colley in the Park again. On behalf of our readers, we trust that he has now recovered from his recent illness.

"Reconstructive Surgery to the Hand"

By Dr. STERLING BUNNELL, M.D., San Francisco.
(*Consultant in Hand Injuries to U.S. Secretary for War*)

A Lecture delivered, illustrated by film, at Guy's Hospital Medical School on Wednesday, June 12th, 1946.

GENTLEMEN,—It is an unexpected honour to have this opportunity to talk to you. We in the States are great admirers of the British for the fortitude with which they have gone through such hardship and peril. I have been looking forward to this short trip to England, and I came not to lecture but to see some of the reconstructive work which your surgeons have been doing. In the States my work in the last year-and-a-half has been that of consultant in hand surgery, and we have tried to develop hand surgery in our Army hospitals because we had thrust upon us 20,000 crippled hands. The Surgeon-General set aside nine hospitals for plastic surgery and assigned those hospitals to do the work on the hands. There were many other hands injured in many other hospitals but they were in cases of multiple injury.

We had to find men to do the work and men who were specialists. The plastic surgeon would not cover the orthopædics, the orthopædist would not cover the neurology, and so on, and we found nine men of ingenious type who would tackle the problem by individual thinking. They had sufficient assistants and trained them so that now there are a good many surgeons in the United States who are doing this work and who have turned out some very good results. It has been very gratifying to see what they have done. Nerve repairs, tendon repairs, tendon grafting, bone grafting, bone correction, correcting the position of the joints. The speciality will probably grow and we shall have some literature on the hand because so many people are becoming interested in it. In fact, we have just founded a society—the American Society for the Surgery of the Hand—and I hope that soon there will be one in England for the same purpose.

The hand has been rather neglected in surgery, but its importance is too great for it to be neglected. Why has it been neglected? We all know that foot surgery has gone ahead very rapidly, but hand surgery has not. The problem of the hand is very complicated and work on it has lagged. It might be compared with art. I remember going through the Louvre in Paris and the guide pointed out that the ancient artists did not model hands and feet, they were just little flippers. There was the trunk and head and posture. We went by many statues until we got to the Greeks who modelled wonderful hands and feet. Later again the art was lost and it is not until the renaissance that hands began to look like hands. That is a good deal like surgery, but now I am sure the subject will develop rapidly and we shall make progress. The importance of the hand will justify it. The manual worker is dependent on his hand, he works with his hand, and injures his hand. In any industrial city there are thousands of crippled hands which need repair, if a man cripples his hands he drops in the social scale, his income is cut down, and he falls to a lower position as a result.

The hand should really be regarded as an entity. We found in our army hospitals that neither the plastic surgeon, the orthopædist nor the neurological surgeon were the chief workers, the entity is the anatomical entity and we found it advisable to segregate the hands and have them treated by men who had studied that area and the principles of repair. The hand should be considered as reaching to the elbow because the muscles which move the digits start from the elbow and the bones of the forearm control the hand, so that mechanically the hand unit should be to the elbow, not to the wrist.

Dynamically the hand starts on the opposite cerebral cortex so when its nerves are damaged the hand is crippled. In the army hospital nerve injuries were under the neuro-surgeon, but those in the upper extremity had the complication of the hand and they had to be watched and taken care of by the hand surgeon; right from the beginning the hand should be kept in the position of function and the joints exercised otherwise they become a stiff core in the position of non-function.

It takes about three-quarters of an hour to go over a complicated hand when making a diagnosis, writing down all the measurements, and so on, and the diagnosis consists of a list of what is wrong with it and then we have to figure how to fix it, by a series of

operations and treatments. The prognosis depends largely on the nutrition of the hand, the repair of the nerves; joints and tendons depends mostly on the nutrition of the hand, that is, the condition of the tissues.

Let us consider the different parts of the hand in turn. I want to give just a rough sketch. I have not time to cover the whole subject, it would take eight hours to do that and I have a few films to show you which give an idea—they are rather rough and crude—of what can be done in the hand in certain procedures. Let us consider first in the problem of reconstruction the covering of the hand. The skin covers the hand, normally it does not blench and it stretches with movements, but in the wounded hand there is a flexion contracture which pulls the skin tight inside the scar tissues which has the effect of cockling the skin which spoils the nutrition of the hand. If the hand is damaged there is a cicatrix on the skin, and if the cicatrix is deep, going all through the hand, binding the tissues, we have to free them because they need vascularity. In a skin operation in the deep part we dissect a plaque of scar tissues including the tentacles which reach out to other tissues. The whole hand is released and now it will open up, it will breathe and bloom again, and get limber and be totally different. All tissue must have vascularity. We have to put new skin on a hand, not a free graft unless it is a burn where the damage is on the surface, but with the deep cicatrix we put in a pedicle graft which allows for a blood supply. They are put on by flaps in one procedure. Another method is to turn over the flap and put the defect up against it, the two-pedicle operation was originated in England by Gillies, and the skin is replaced. It is important never to have the border of the pedicle where it can do harm, the skin will stretch but the border will shrink. It is like an incision, it will contract. It is very important in all incisions in a hand or in any part of the body where a pedicle is used to avoid cross-inflexion of the creases or a right-angle, because at every motion of the hand there will be a push and a pull on the scar, which will hypertrophy all connective tissue. That applies particularly to procedures on the hand or wrist. Remember these two thoughts, that the medial longitudinal incision is pernicious in the hand, have it along the line of the wrinkles the scars then become invisible. In putting on new skin you should just cover the whole posterior surface and have the juncture made level.

Let us now consider some other tissues. Take joints which have a tendency to stiffen and that is our big problem. The hands become stiff and they stiffen in the position of non-function. They stiffen because they are put together so correctly, the ligaments are just long enough, there is no sideplay, and anything that changes their length will stiffen the joint. When the hand is swollen it is oedematous and fibrin is precipitated. The joints and little folds have the fibrin precipitated right round them and we get fibroblasts in the tissues making them solid so that there is no movement. When the joints are straight the ligaments are loose, but when the joints are bent the ligaments are taut and there is no lateral play. If we allow the joints to hypertrophy in the straight position we shall not get them to move again without a struggle, but if they are flexed they will always straighten, the ligaments will be long enough. Why does a limb go into that pernicious position ? It is because when a man has a sick hand he holds it and protects it and the wrist conforms to the trunk in flexion. The normal position of a hand is *this*; the wrist is a little flexed, the fingers are semi-flexed, the thumb is semi-opposed to the fingers, and the straightening-out is the commencement of all motion. When a hand is sick the wrist contracts, that tightens the extensor tendons and the hand assumes a position of non-function, the proximal finger in extension or hyperextension with the thumb to the side of the hand, drawn back by the tightening of the tendons. Unused muscles shrink a little and that exaggerates the tightness, if the muscles were a little short we should do *this* automatically. That is what happens. The patient has only half-an-inch of motion and that is useless, there is no freedom, he does not use the hand, he holds it down, and it stiffens more and more, he has disconnected it from his brain, and it is just there as a club.

The first thing to do is to get the joints in the right position, put the wrist into true flexion with the spring splint so that it can be worked, the other joints will then go into a more natural position ; put rubber bands on the proximal finger joints and a rubber band to draw the thumb into the opposing position, thus getting them back into the position of functioning. They have a half-inch of motion and they will use it more and more. That is the start, to get the joints into functioning positions. We do it by a system of active splinting, springs or elastic. We have gathered all the modern ideas together and made a set of splints which will do it and which will really work. The advantage of active splinting is that it keeps the muscles mobile so that

they pump out the toxins, it keeps the joints and the tendons moving the surface clotting. A spring splint will mobilise, not immobilise; rigid splints make rigid hands. A spring splint will exercise, and the person will keep using it all the time, working against the spring of the rubber band or the spring steel.

If we cannot get movement in this way we carry out capsulectomies; if the joint is destroyed we do ortho-plastics.

Bones are often injured in gunshot wounds. Such wounds will almost wreck a hand if too many of the tissues are injured and all we can do is to amputate it, but if the tissues are intact we can repair the bones. Bone grafts are best from the limb, tibial grafts are all right but the cancellous bone is safer. The cortical bone takes two to three months to unite, iliac grafts take five weeks, so do ribs but they are not so convenient. The method adopted was pinning, we pinned them with fine Kirchner wire, it was pinned transversely or through the graft into the shaft, or it was pinned longitudinally, cut through the end of the metacarpal, coming out by the wrist, the wire being drawn in until it cleared the cartilage of the metacarpo-phalangeal joint, and snipped off at the skin. The wire should be under the skin, not through the skin, otherwise there will be infection.

There are many problems with the metacarpal bones. When the head of the metacarpal is worn we take it off at the base, if the centre has gone that is bad, then we take out the whole lot, narrow the whole hand, bringing the marginal metacarpal over to the inner one, or we can recess it down and join it to the metacarpal thus giving a short finger. If the ring finger has gone take the middle one, and so on. We can put these metacarpals back so strongly by pinning that a capsulectomy can be done at the same time which saves time in treatment.

A capsulectomy should be kept rigid for a week, then the rubber bands can be put on and kept on for six weeks. We must maintain the flexibility of that joint. There are many ways of doing so.

Tendons usually have to be repaired by tendon grafts. It has been found that grafts will grow and the tendon of the hand will grow. Such grafts can be done with impunity, if a big graft is done the centre will necrose, but a little graft will grow. There is a special way to suture a tendon. If we sew it with silk we push the ends together and zig-zag them through, put one in and pull straight and hide the knot, then tie the knot and it will sink out of sight, the tendon being brought together with a core suture splice for a certain length; there are no knots between and it is quite strong. The knot is where the strain is least. Putting the silk through back and forth you will suture one thread with the other, to avoid that put the needle through simultaneously and that will work. Another stitch can be done with stainless steel. To illustrate the need for that I will mention primary suture of a tendon of a finger. That is something in which nobody succeeds very well the world over, the severance is between the crease in the palm and the crease in the middle of the finger. If the tendons are separated there it is rare to see a good primary repair, but a good repair can be obtained by paying attention to a lot of little details. If the sewing is done with silk there will be a reaction and it will adhere so it is best to use stainless steel. If it is sewn here it will swell, and the blood supply will be pushed out, necrosis will occur and there will be a mass of scar within the finger. To avoid that see that the tendon can swell and can breathe and avoid necrosis. If you put in the stainless steel wire you only have to put it in one tendon end and out through the other and then out through the skin and fasten it. One thing more, do not put in the stitch where the juncture is at all, leave it free from anything which could make it adhere, débride it carefully, open the palm, put in the stainless steel wire, weaving it in, then bring the wire down through the skin to the fold of the end of the palm, pull the tendon down until it is the right length and tie it on the button, the muscle cannot pull, and the two tendon ends in the finger lie together with no tension. Be sure that you can extend the finger so that it will not pull apart, and then close the wound. In this way you have done the least possible to make adhesions. Put the wrist up in flexion for three weeks. Then the sutures are cut under the button and with a pull-out wire draw out the sutures. The suture that makes the least adherence is the suture which is not there. Get the patient to move the finger, and sometimes you hear a snap and that is the adhesions breaking down. Sometimes you get a finger which goes down almost to the bottom of the palm, a little distal, that is the principle of the use of the stainless steel wire, it makes the least reaction in the tissues and it is removable. When you put the wire in you put a stop on the tendon end and then do the sewing, then put on the pull-out wire and hold it so that the tendon is taut, then take the two wires

and pull them back until you are sure they will pull out. Also straighten the loop so that it is not big enough to include tissues in its grasp. A twist will prevent tissue getting in. One can use that stainless steel wire all through the body and pull it out as soon as the tissues heal.

One of the big functions in the hand is sensation, it is equal to motion in importance, and the great mass of nerves is in the fingers and thumb, the eyes of the hand. A man cannot work properly unless he can feel so that it is extremely important to get the little nerves back if possible. If they are not back all the little muscles will atrophy; if they are not seen too quickly they will not recover. The nerves should be sewn soon, the sooner the better. The primary sutures give the best results. To let a nerve go for a year or a year-and-a-half is criminal, because the muscles have undergone fibrous atrophy and there is no come back. We often attend to the bone first and leave the nerves till later, that is lost time and the muscles atrophy, not entirely beyond repair, but they are much handicapped. The nerves within the hand are big enough to suture, and they are easy to suture, four or six being put in. Very fine silk is good, and the nerves can be sutured as far as the distal crease in the fingers. These little nerves come back better than any other nerve in the body, the nearer the periphery the better the regeneration, from the wrist down the nerves are pure nerves since the motor branches have come off. It is well worth while repairing the little nerves in the hand.

Dr. Bunnell then showed his films, the first showing the intrinsic muscles of the hand, their physiology and action, the second showing reconstructive surgery of the hand showing skin and bone grafting and other procedures for the repair of crippled hands. The third film dealt with actual cases of hand injury and showed how they were dealt with and the results of the work carried out.

Mushroom Poisoning in a Diabetic

BY A VILLAGE DOCTOR.

IT is surprising that poisoning from eating edible fungi does not occur much oftener. There is an old gentleman living near me who goes around scraping those horrible-looking fungi from the trunks of trees, which he regards as a great treat. Although articles appear in the medical journals from time to time on the subject, it is surprising how little the text-books have to say about mushroom poisoning. Price's Medicine, for instance, merely says in the section on "Poisons Acting on the Liver":—

> "Poisonous fungi eaten in mistake for edible mushrooms are powerful liver poisons. They usually cause acute gastro-intestinal symptoms, and in severe cases these may be followed by symptoms of acute auto-intoxication due to suppression of liver function consequent on the intense degeneration of the hepatic cells."

No recommendations as to treatment are given.

Poisoning may actually occur from real mushrooms. The symptoms have been described as resembling those from muscarine, which is said to occur in many mushrooms. Mushroom poison acts as a neurotoxin and as a hepatotoxin, and it is by the latter action that serious liver damage may occur.

This may be serious enough in a normal healthy person; but when it occurs in one who is the subject of diabetes the condition may rapidly become critical.

Tidy describes the symptoms as:—

"(1) Restlessness or actual delirium; (2) Dilatation of pupils and disturbance of vision; (3) Slow pulse; (4) Diarrhœa and vomiting . . . but rarely are all present."

There are many forms of food poisoning in which vomiting and diarrhœa are prominent, and it is most important to make a diagnosis at the earliest possible moment. A direct enquiry will usually reveal whether mushrooms have been eaten or not. Although they may not be the actual cause and the diarrhœa and vomiting may be due to another cause altogether, the fact that they have been eaten should prompt one to look for confirmatory signs. A slow pulse, 55 to 60 per minute, or even slower, is probably of the greatest value. Dilated pupils and blurred vision would be further strong confirmation. In some cases there may even be restlessness or delirium. Very

similar symptoms may be seen in solanine poisoning, from eating old, black or "shooting" potatoes. The potato belongs to the order Solanacese, which includes Deadly Nightshade or belladonna, and solanine is isomeric with atropine. The dilated pupils and blurred vision seen in solanine and atropine poisoning are associated with a greatly increased pulse rate, whereas in mushroom poisoning it is slowed; that is why the pulse should be very carefully investigated.

When these cases occur, they crop up as acute emergencies. If the mushrooms have been eaten at night at dinner, you are likely to be called out at about 3 or 4 a.m. Do not forget to ask whether the patient has had mushrooms, but exclude solanine poisoning, as the correct antidote for mushroom poisoning is a fiftieth of a grain of atropine sulphate administered hypodermically, whereas this must on no account be given in solanine poisoning, for obvious reasons.

Another factor which may assist a diagnosis is the character of the vomiting and the vomited material. The vomiting is almost continuous. Yellow bile-stained fluid is produced, not in very large quantities at first but becoming more copious and darker until it is dark green. The total quantity of this fluid is almost unbelievable, containing more and more bile as time goes on, and may even lead to desiccation.

Atropine Sulphate gr. 1/50 being a direct antidote usually checks the vomiting after a while but only for a short time. The patient may or may not retain some iced soda water during this interval. If the pulse is, say, 54 to 56 when the atropine is given, it may have risen to 80 or 90 about half and hour afterwards as the vomiting is checked. But the rate begins to fall again and in 1½ to 2 hours it may be down again to 58 or 60 and the vomiting will recommence. A further gr. 1/50 may be given with similar results, but it obviously cannot be repeated indefinitely and other measures must be taken. The stomach should be washed out repeatedly as soon as possible, as fragments of the mushroom are very apt to adhere to its walls.

The most effective remedy is the Sérum Antiphallinique, prepared by l'Institut Pasteur de Paris, of which an initial dose of 40 c.c. may be given intramuscularly after a small intradermal injection of about 0.5 c.c. to test sensitivity. This dose may be repeated if necessary.

Case History.

A lady of 55, a mild diabetic, living on a balanced diet of 2,000 calories with 9 units of insulin in the morning and 8 units at night, had eaten at about 8 p.m., as the final course at dinner, one small cultivated mushroom on toast. At 3 a.m. she was seized with acute vomiting and diarrhœa and cramp in the feet. The vomiting was of the character already described. The bowels were opened three times in about two hours, after which the diarrhæa ceased. The pupils were well dilated and the pulse 58, in spite of the exertion of repeated vomiting.

Although she was fond of mushrooms, and had often eaten them, she had never had any ill effects before.

A diagnosis of mushroom poisoning was made and atropine sulphate gr. 1/50 injected. This checked the vomiting within 20 minutes and in half an hour the pulse was 90.

As the patient was a known diabetic with a resting blood sugar of 165 mg. per cent., the serious import of the combination was at once realised. She was quite unable to take food and in the circumstances insulin was withheld.

Much valuable time was lost telephoning to every likely and unlikely source of supply in an attempt to obtain Sérum Antiphallinique, but in the meantime the pulse rate had fallen again to 60 and the vomiting had recommenced. A further gr. 1/50 of atropine was given and the telephoning was resumed until it was obvious that there was none of the serum in this country. As I was determined to get it, I got in touch with the French Embassy, who have a through line to Paris, and explained exactly what was wanted. Very shortly afterwards they rang me up to say that they had been through to the Pasteur Institute who had despatched the serum by car to le Bourget and it was being brought over on the Diplomatic Plane. By the good offices of the Ministry of Supply a free Import Certificate was issued and I awaited the arrival of the serum.

In the meantime the blood and urine were examined. The blood-sugar had risen to 268 mg. per cent.; the urine gave a strongly positive reaction for sugar with Benedict's reagent and contained a quantity of acetone. Whether this was the harmless acetonuria of starvation or whether it was part of a diabetic ketosis it was

not easy to say. There was no smell of acetone in the breath and the patient was not drowsy, so I hoped for the best.

The vomiting started again as the effect of the atropine wore off, and I did not care to repeat it for the pupils were now fully dilated and accommodation paralysed.

There was a special reason why waiting for the arrival of the serum was exasperating to a degree, for nothing I could do would relieve the vomiting. The total amount of liquid vomited was enormous and the patient was rapidly becoming dehydrated. The Pasteur Institute telephoned me from Paris and gave instructions for giving the serum, for which I was most grateful. The Airfield rang up to notify the time of arrival of the plane and my daughter, who is a well-known racing motorist, went to collect it. In due course it arrived and 40 c.c. were given intramuscularly at once after a preliminary intradermal test had been performed. Within twenty minutes the vomiting had stopped and then the chief anxiety was the diabetes.

As the vomiting was not primarily gastric, an egg beaten up in ten ounces of citrated milk was given during the next hour.

In view of the acetone, two drams of sodium citrate was added to the milk, and five ounces of milk containing one dram of citrate was given every hour. This was retained and enjoyed, as was Brand's Chicken Essence. Within 24 hours of the cessation of vomiting the patient was allowed a feed of pressure-cooked chicken. She was hungry, enjoyed it and kept it down. Soda water *ad lib.* was given. The insulin was recommenced in the doses adequate before the illness, but the urine showed evidence of much sugar and so it was stepped up, unit by unit, from 9 units in the morning and 8 at night, until the urine was sugar-free. This was achieved with 15 and 14 units respectively without hypoglycæmia.

As the patient had been resting in bed during this time, and was normally a very active woman, it was thought that she had not been metabolising as freely as usual, so she was allowed up, feeling weak but not hypoglycæmic. With increased muscular effort she had slight hypoglycæmic symptoms, quickly relieved by a lump of sugar, so the insulin was gradually decreased to 12 and 10 units. It was hoped that as the liver damage was repaired the initial 9 and 8 units would again be sufficient. On the 14th day, one hour after the administration of 12 units of insulin and half an hour after breakfast, the blood-sugar was 112 mg. per cent. without hypoglycæmic symptoms. These appeared slightly just before lunch and were again relieved by a lump of sugar.

The reason why it was so exasperating waiting for the arrival of the serum was that we were in the country, 36 miles from the airfield, and the patient was—My Wife.

H. M. S. T.

Obituary

V. R. ESTMENT, L.D.S.

VIVIAN ESTMENT joined Guy's in 1919 after service under Smuts in the African campaigns. He won the Entrance Scholarship in Dental Prosthetics in 1921, qualified in 1924 and was appointed house surgeon in the Prosthetic Department. He took part in normal Hospital activities, got his half blue for cricket and played rugger for the A team. After his return to South Africa in 1924, he set up in practice in East London, later being appointed maxillo facial specialist to the Frere Hospital. He was no great letter writer, but he kept up an infrequent correspondence with some of his friends here. When rationing was introduced in England during the late war, Estment remembered his old colleagues in a very practical manner. At least four Guy's men and their families, as well as other friends in England, regularly received food parcels from him up to the time of his death. He was in poor health and was never a rich man, but he spent his time and energy, as well as his money with complete and selfless generosity for the benefit of his friends.

Estment loved Guy's; and no son of Guy's ever more truly exemplified the spirit of our Founder's motto, "*Dare quam accipere.*"

E. A. L.

Reviews

Neurosis and the Mental Health Services. By C. P. BLACKER, M.D., F.R.C.P. 1st Edition. Oxford University Press. *Price* 21*s.*

MR. C. P. BLACKER has done credit to the most difficult task he set himself when he undertook a survey of the country's Mental Health Services, and his report entitled Neurosis and the Mental Health Services provides stimulating reading. Although the immediate purpose of the survey was to bring about a better co-ordination and distribution of the then existing psychiatric services which had been depleted by the fighting services and the E.M.S., it was hoped that it would play some part in defining policy and aiding in a better integration of the country's health services after the war.

Dr. Blacker is to be congratulated for refusing to limit himself to the rather narrow terms of his commission. The most refreshing part of his report lies in those sections where he allows himself to write from a more personal standpoint and where he discusses freely the social problems connected with mental defect and subnormality, psychosis, neurosis, epilepsy, recidivism, delinquency and inebriety.

The author reaffirms the need for a closer connection between general medicine and psychiatry on the one hand and between institutional psychiatry limited to psychosis and mental defect and medical psychology embracing neurosis, child guidance, industrial psychiatry and prevention on the other. This is most encouraging and helps to answer some of the critics of present day psychiatry who see a potential danger that this branch of medicine will tend to become more and more isolated from the body of general medical thought and at the same time accept a scarcely justifiable right to direct and control the conduct of the citizen whether he requests such aid or not. It is some consolation to know that before the psychiatrist becomes the undisputed master of personnel selection in all branches of commerce and industry as well as in the fighting services he himself should be subjected to some form of selection and training. He points out that more and better trained psychiatrists are needed and the supply and training will depend on the efficiency of the Teaching Psychiatric Units of the Universities whose staff should aim at attracting into the specialty keen and able students with active clinical interests.

All in all one cannot speak too highly of the tremendous amount of valuable work done by Dr. Blacker in collecting these statistics and giving a factual view of the psychiatric services as they exist to-day.

Space is too short to permit a full summary of the work done in the report and the field covered, but it can be recommended as probably the most comprehensive one on its subject in this country. The report is in many ways a provocative one, but no one interested in the problem can say that he has not put forward his views forcibly and sincerely and backed them up with sound arguments. There is much to be learned from this report that will be of value to those concerned with the future development of the country's health services.

A. MACL.

Anatomical Atlas of Orthopædic Operations. By L. S. MICHAELES, M.D. 1st Edition. Heinemann. *Price* 25*s.*

IT is notoriously difficult to describe how to do anything practical by word and picture. Unless each step of the procedure is described and shown in detail, any such instructions are useless to the uninitiated and merely serve to encourage him to get out of his depth. At the same time, such detailed instructions are of little interest to the experienced surgeon. Mr. Michaeles has attempted the impossible, namely, to provide a primer of orthopædic operations. It provides insufficient information for the surgeon who is occasionally called upon to perform an operation which is unfamiliar to him, and is too elementary to act as a reference book for the orthopædic surgeon proper.

One has the feeling that, if any surgeon was really enlightened by reading the description of any operation in this book, he would be wiser to refrain from performing the operation at 'all.

T. T. S.

Gynæcological Endocrinology for the Practitioner. By P. M. F. Bishop, D.M.(Oxon.). 1st Edition. E. & S. Livingstone, Ltd. *Price* 7*s.* 6*d.*

GYNÆCOLOGICAL endocrinology is a big and confusing subject, of which there is still much to be learnt. However, there is sufficient known for a coherent presentation of the subject to be given; the difficulty for the student and general practitioner has been that most published work has been bulky, if comprehensive, or else consists of specialised articles in the journals. The merit of Dr. Bishop's book lies in its lucid presentation of the subject within the compass of 80 pages. As far as possible, controversial matter is avoided. The brief discussions of clinical conditions are good, and the claims made for endocrine therapy are eminently fair and based on a sound critical appreciation of results.

The book meets a very real need and should help stop the misuse of hormones and encourage their proper use. At the end, there is a useful appendix setting out the different proprietary preparations, giving their nature and dose.

J. B.

Injuries of the Knee Joint. By I. S. Smillie, O.B.E., F.R.C.S.E. 1st Edition. Livingstone. *Price* 35*s.*

THE last six years have provided an unrivalled opportunity to many orthopædic surgeons to gain a wide experience of the complex injuries to which the knee joint is liable. It was to be hoped that someone would have the time and energy to record all that has been learnt for the benefit of coming surgeons, and we owe a debt of gratitude to Mr. Smillie for having done the job in such a thorough and admirable way.

This book provides a wealth of information—in fact, this is its chief fault, for the emphasis on the most important and essential features of these injuries tends to be submerged in such a comprehensive survey, and this lessens its value as a book for students. As a work of reference, however, it should be in the hands of every surgeon called upon to deal with such injuries.

T. T. S.

Practical Chemistry for Medical Students. By W. Klyne, M.A., B.Sc. 1st Edition. E. & S. Livingstone. *Price* 20*s.*

IN spite of the general similarity of content, the practical courses of elementary chemistry vary widely, largely in their manner of presentation and to some extent in the choice of illustrative experiments. This explains the large number of available texts and the limited field of their appeal.

The present work, which is an expanded version of the practical course at the University of Edinburgh, differs from most in that considerable emphasis is laid on scientific method. Part One, which deals with general scientific principles could, as Prof. Marrian remarks in a foreword, "be read with great benefit not only by medical students but also . . . by science students."

There follow sections on apparatus, including details of its use, physico-chemical principles, volumetric analysis, and some experiments on physical chemistry. The arrangement, while very systematic, is going to be very irksome in use. Thus a melting point determination is described on p. 65, while mixed melting points are dealt with on p. 120; again, volumetric analysis occupies pp. 129–158, but a student must turn back to pp. 57–64 to learn how to use the apparatus. The remaining parts of the book are devoted to inorganic chemistry (the experimental portions are conventional) and the chemistry of organic and biologically important compounds.

The number of practical experiments detailed is, as the author admits, far greater than could be performed in the time available. In addition, a considerable amount of theoretical knowledge is interspersed, and desirable as this may be the effect is greatly to lengthen the book. The reviewer feels that an elementary student, even with careful guidance, will probably be rather overwhelmed by the mass of detail in it. Nevertheless, the book is a valiant attempt to depart from the historic cookery-book tradition, and to present the subject on modern and logical lines.

R. E.

The Anatomy of the Bronchial Tree. By R. C. BROCK, M.S. 1st Edition. Oxford Medical Publications. *Price* 42*s.*

THIS book is obviously the result of much painstaking and accurate research which corrects many inaccuracies of previous descriptions of the anatomy of the lungs and places the topography of these organs on a new and rational basis founded on the distribution of the bronchial tree. New information is given also about the level of the bifurcation of the trachea and the level and form of the interlobar fissures. The importance of an exact knowledge of the various broncho-pulmonary segments and the influence of posture in the incidence, spread and treatment of pulmonary disease are made abundantly clear.

The text is very well written throughout. A slight improvement might be effected by a rearrangement so that the purely anatomical parts of the work would precede the clinical applications.

The figures illustrating the text are admirable, especially the bronchograms. Fig. 141 would be greatly improved and would constitute an excellent summary if enlarged and coloured to conform with other figures. The labelling of the various branches of the bronchial tree in the same figure and in Figs. 120 and 121 would also be helpful.

A thorough knowledge of the book is absolutely essential for the thoracic surgeon and familiarity with the main principles will be of great assistance to the medical practitioner in the management of lung disease.

The author is to be congratulated on the production of a polished record of a very valuable piece of research.

J. W.

The Nervous Child. By H. C. CAMERON, F.R.C.P. 4th Edition. Oxford University Press. *Price* 10*s.* 6*d.*

IT is over a quarter of a century since the first edition of this little book was published, and one agrees with Dr. Cameron that it would be a difficult task and a pity to re-write it completely. Each edition has been brought up to date and it remains an excellent book full of sound reasoning and showing a clear understanding of the child's mind.

This book should be read by all nurses, students, and doctors, but it should be remembered that every child is not a "nervous child," although all children are nervous at times, and that this is not a text book on Child Health—it is just a very good account of nervous manifestations in childhood and how to treat them.

F. R. B.

The Chemistry and Metallurgy of Dental Materials. By J. CAMPBELLSMITH, B.Sc. 1st Edition. Blackwell, Oxford. *Price* 21*s.*

THE practice of dentistry requires the use of so wide a range of materials that it is difficult to write a textbook which is at the same time both readable and comprehensive.

In the first of the three sections into which the subject matter is divided, metals and alloys are discussed with simplicity and clarity. An adequate minimum of theory has been provided but the emphasis has rightly been laid on the practical aspects, and no major topic seems to have been omitted. The second part deals with the rest of the inorganic field—impression materials, investments, cements, etc.—and a feature is the amount of tabulated data. The final section deals with organic substances, *e.g.* rubber, waxes and plastics. Lest the increasing use of synthetic materials should leave the student floundering, the last sixty pages contain a sketch of the basic principles of organic chemistry. These chapters are not strictly relevant to the main theme and opinion will be divided on the value of their inclusion. Their presence, however, in no way detracts from the merits of the book as a whole. The index is satisfactory, while the references to the literature (most of them very recent) will be valuable in seeking further information.

Altogether, this excellent book can be strongly recommended to all dental students beginning their professional studies.

R. E.

STUDENT TYPES
III. SPORTING

Correspondence

"Medical Learning and Medical Language"

SIR,—May I apologise to your readers for some errors that appear in the printing of my article on Medical Learning and Medical Language? Having to make an alteration in MS. in the section on "ize," I fear I baffled the printer so much that one or two sentences are reduced to nonsense.

There is the mysterious "pschizien": how many could guess it was "psephizein?"

I am, etc.,

Orpington. H. ST. H. VERTUE.

"Advertising"

SIR,—I am assured that only products of proven value are allowed advertising space in the *Gazette*.

I should be interested to know the formula and results obtained at Guy's by the use of Curicones.

It isn't a new remedy.

It was launched in that era which, as Dr. Vertue has pointed out elsewhere, bred "not only firm judgment, but indifference to popular clamour"; and also fostered, as he omitted to mention, that love of accuracy and truth, so notably upheld by those crusaders of unrestricted free enterprise, the vendors of patient medicines.

If the name of the product does not offend the conscience of the schoolman, perhaps Dr. Vertue might be the one to "give us the gen" on this *Gazette* sponsored, re-juvenated, therapeutic marvel.

Yours etc.,

J. N. O'RAFFERTY.

Pastoral Opinion

SIR,—I enclose herewith my own opinion and experience with regard to the failing cheerfulness of the nurse through her training.

Fear is the dominant theme in a nurse's early training. Fear of humiliation, reprobation and bad reports. Fear of failure and the traditional fear or chicken-heartedness to speak up to her seniors even in the face of justice. This fear is fostered and nourished in the present system despite various improvements.

The remedy for the failing cheerfulness of the young nurse is the dissolution of this fear—and only one person can do this, the ward sister.

Let us at Guy's start a tradition of cheerfulness by an enlightened co-operation and education of nurses and refute the old tradition of fear and petty humiliation.

Yours, etc.,

Nurses' House, ANONYMOUS.
Guy's Hospital.

[ED. This correspondence is now closed.]

Sport

Rugby

GUY'S *v.* UNITED SERVICES (PORTSMOUTH).

(*Played at Honor Oak Park, Sat., 5th Oct.* 1946.)

Result: Guy's 17; United Services 14.

It is pleasant to note that the match against United Services was started promptly to time, and one hopes that this consideration for the spectators will continue throughout the season.

We had the pleasure of welcoming I. H. Hilliam and N. K. Macrae-Gibson in the opposing team, but the latter within 9 minutes of the start completely baffled at least four Guy's defenders by crossing under the posts for R. Whaley to convert. Two minutes later, D. M. Strathie dropped a magnificent goal and from then until ten minutes from the end Guy's were well on top. Guy's had a capital pair of halves in P. D. V. Harrett and D. M. Strathie, but the three-quarter line did not work at all smoothly, due mainly to N. K. Macrae-Gibson forcing F. Van der Westhuizen, playing his first game of the season, to run wide, thus cramping any chance F. Le Clus might have had in breaking through. D. M. Strathie was in brilliant form and just before half-time scored a solo try and T. L. T. Lewis followed with a penalty goal.

Soon after the restart F. Van der Westhuizen dropped a goal and scored a good try

from an opening by F. Le Clus who had intercepted an opponent's pass. It was then that Guy's lost T. L. T. Lewis through injury and A. De Villiers went to full-back, and no doubt this enabled the Services forwards to break through our own pack and play havoc with our backs, which brought them a penalty goal by R. Whaley, and tries by Sindery and Peel.

It appears that Guy's have several weaknesses, the most important being the inability of F. Van der Westhuizen to beat his man and run straight. The wings had few chances in attack owing to being cramped on receiving the ball, and the forwards failed to bunch round in the loose rushes made by the Services pack following Lewis's injury. F. Le Clus at left centre gave an impressive display.

Hospital Information, etc.

Notices

DEPARTMENT OF SURGERY.

In the near future it is hoped to organise various activities in connection with the department. As a start, it is proposed to arrange combined rounds for post-graduates and at these old Guy's men will be especially welcome. The rounds will be held on the second Saturday of each month, beginning on November 9th at 10 a.m. Mr. Grant Massie will conduct the first round.

In addition, on the first Tuesday in each month, starting on November 5th, there will be a demonstration of standard surgical procedures to which registrars and house surgeons are invited. In the course of a year it is hoped to cover all the standard operations, but it will be impossible to give more than a few days notice of the specific operations to be performed at any one session.

H. J. B. ATKINS,
Director.

THE 41st ANNUAL DENTAL DINNER.

The Committee of the Dental Society has very much pleasure in announcing the resumption of the Annual Dental Dinner. This first post-war reunion dinner is to be held in conjunction with the Dental School's Clinical Day on Saturday, 29th March, 1947.

During the morning and afternoon of this day there will be demonstrations in the Dental School of the latest developments in dental practice, and also Clinics, at which recent interesting clinical cases will be reviewed.

To wind up this occasion, there will be the 41st Annual Dental Dinner at the Grosvenor House, Park Lane, to which all Guy's men who qualified between the years 1889 and 1947 are specially welcome. Professor Rushton, the Society's President, will be in the chair.

Tickets, price 25s., will be obtainable early in the New Year from the Secretary of the Society.

Dinner Committee.—W. J. Tully, A. W. Hilliam, W. G. Selley.

DENTAL SOCIETY.

The President for this season is M. A. Rushton, Esq., who is the first Professor of the newly created chair of Dental Medicine. The Society is pleased that he will be their President for the coming season, for next March, the Clinical Day and Dental Dinner, an annual event before the war, is to be reinstituted. The Dinner is the special province of the Society, and the whole occasion was described at a Press lunch in 1938 as the "largest dental gathering of its kind in the Empire."

Three regular features of the Society are to be retained this year, the Dance in November, the Dental Brains' Trust next Spring, and the free teas before each meeting, the size of which will be increased as soon as catering is easier.

Those working in the Lab. often feel that the Society is not for them. They are wrong; they have two representatives on the committee and the meetings can be as much for them as for anyone, if they care to attend. At some meetings specialised papers are read but many are of general dental interest, and there is always room in the Society's programme for anyone who feels he has something to say either in the form of a Casual Communication or a Paper.

S. P. JOHNS,
Hon. Sec

THE COMMONWEALTH FUND FELLOWSHIPS—1947–48.

Applications may now be made for the Commonwealth Fund Fellowships for the session 1947–48.

Candidates should be qualified men and those with experience in research work and post-graduate study will be given preference. Evidence of proficiency in some recognised branch of university learning must be submitted.

All applications must be submitted on the prescribed form by 1st February, 1947. Further particulars and forms of application may be obtained from the Medical School Office or the Secretary to the Committee, 35, Portman Square, W.1.

DEMONSTRATOR (FULL-TIME) OF ANATOMY.

Applications are invited for the appointment of Demonstrator (full-time) of Anatomy. Salary £450 p.a. with superannuation. Applications should reach the Dean not later than 29th November, 1946. Duties commence 1st January, 1947. Forms of application obtainable from the Medical School Office.

The Services

Killed in Action.

Lt. C. M. Morris, No. 9 Commandos, killed in action on April 2nd, 1945, whilst serving at Lake Commachie, Italy.

Marriages

DUNPHY—STEWART.—On September 7th, 1946, at Folkestone, Patrick Dunphy, eldest son of Col. L. O. A. Dunphy, of Dunsford, Exeter, to Sydney Isabel Mary, eldest daughter of W. T. Stewart, of Tanganyika Territory.

Deaths

BENNISON.—On 19th August, 1946, Philip Carr Bennison, M.B., B.S., of Oakhurst, Bournemouth Park Road, Southend-on-Sea.

ROSENBERG.—On October 14th, 1946, at Bombay, India, of Typhus Fever, Capt. D. Rosenberg, R.A.M.C., Husband of Frances (née Kavanagh).

EDS. {R.T.H. D.H.F.

GUY'S HOSPITAL GAZETTE

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PASSIM

" If women could be fair, and yet not fond,
Or that their love were firm, not fickle still,
I would not marvel that they make men bond
By service long to purchase their goodwill. . . ."

THUS wrote Edward Vere, Earl of Oxford, during the sixteenth century. The rest of the poem shows clearly that gentleman's sentiments with regard to the fair sex, referring to them as " haggards wild " and " gentle birds that fly from man to man." These feelings, even in these enlightened days, may still be shared by many.

Proof that this opinion is not general, however, may be obtained by consulting the press where, daily, long columns of proposed and accomplished marriages meet the reader's eye. Even our own hospital journal presents notices of such events and when it is learnt that an unqualified student plans to take or has taken the matrimonial plunge the age-old argument is renewed and discussed with ever eager enthusiasm : " Fancy marrying when he can't really afford it ! Not fair on the poor girl and besides he . . .," and so on—the same old remarks are passed and the customary platitudes preached. A somewhat different face is presented, however, to the young couple and they never fail to set out on their ill-timed extravagance with the blessings of their numerous, though secret, critics.

It is true that, by marrying before unqualified days are over, an added responsibility is made over to the young bridegroom's care, but that this addition is necessarily a mistake or even a hindrance is often incorrect. While the early years must, of necessity, be largely occupied with academic pursuits carrying no financial remuneration, it is often these *difficult* days that, in retrospect, are regarded as the happiest and most worth-while. To have shared the trials and tribulations of studying for and, even more important, passing examinations is an experience that must nearly always be greatly treasured.

Naturally, for such marriages to be successful, it is essential that both partners should understand fully the sacrifices that they will be obliged to make before they can settle down to the normal run of married life, that is, as normal as any doctor's married life can be. If the wife has been a nurse she will realise her husband's duties as a conscientious student and the time that they will occupy. The fact that she has this knowledge may or may not be an advantage to the husband !

Another question arises. If a student is going to marry, when is the most suitable time ? The answer to this is, of course—when he wants to. It may be suggested, nevertheless, that the marriage undertaken in the early student days, while presenting a longer period of unrewarded labours (from a financial point of view !), does at least enable the couple to recover from the " first, fine, careless rapture " and adapt themselves to their new life before that last wearying contest that is fought either on the battlefields of Kensington or Queen Square.

The student-father problem is a much more serious affair than the student-husband concern, but may be considered to be a natural consequence of the latter. Here an even keener spur to successful endeavour is present for no father wants the years to slip by to such an extent that he runs the risk of being his son's ward clerk or even on

the same firm. This would be a most deplorable state of affairs, and the poor father would certainly lose face! This danger is, fortunately, almost negligible. Children are expensive things and unless some charitable relative provides what is vulgarly known as "the necessary," a reasonably substantial private income is essential.

In conclusion, we should like to wish all our newly-married readers a pleasant honeymoon and a successful future, and remind those contemplating this venture, by way of warning, of the concluding lines of the same poem which began this Passim—

"... *And then we say when we their fancy try,*
To play with fools, O what a fool was I!"

OCTOBER is ended and by the time this Passim appears a new batch of young doctors will have qualified. All of them will be starting their first authoritative post as qualified medical men and are doubtless looking forward to a successful and interesting career.

The difference between a person's knowledge and skill twenty-four hours before and twenty-four hours after he has qualified must be negligible, and yet the fact that he has, so to speak, passed the test, bestows upon him a far greater degree of responsibility than existed before he signed the medical register. It is to be hoped that his work was always meticulous and that, even as a student, he appreciated the carefulness that was expected of him, but now he is, to some small extent at anyrate, away from the watching eye of his master and he must make certain decisions by himself.

It must be realised that the professional experience of the new houseman can be no greater than that of the senior student about to take, or complete, his final examinations. No one expects the mere acquisition of a university degree or diploma to act like a magic wand and imbue the fortunate receiver of its influence with phenomenal powers of diagnosis and operative skill. These are the happy results of hard work, years of experience and—years of making mistakes.

Yet so often it seems to be considered that these powers are acquired overnight and, together with them, the privileges of seniority. Unfortunately, a certain number of new house officers, while still in their very green years, take it upon themselves to treat their student colleagues as mere underlings, not yet worthy of considered opinion. The game of "playing the pundit" is begun and as the sports jacket and flannels are discarded to yield place to the customary pin-stripe, so the individual develops into a little tin god whose sense of his own importance swells each time he sees a patient.

This picture may seem alarming but so often men, amiable and popular as students, have become such conceited doctors that their popularity and previous spirit of good fellowship have vanished completely during their first house appointment.

The new house officer can be, for the student, a most useful source of instruction, for he is the beginner experiencing all the difficulties and pitfalls of many new and varied tasks. The knowledge thus acquired should be imparted with the air of a friendly colleague, not that of a vastly superior being. No matter how experienced, how successful and, indeed, how famous one becomes, it is important not only to maintain the dignity of this great profession but, far more essential, to preserve those qualities of a human being which keep him in society rather than above it.

WITH deep regret we have learned of the tragic death of Miss Elizabeth Clay, an ex-Guy's masseuse, while climbing in India. We extend our sympathy to her parents and relatives in their sad loss.

FOLLOWING the formation of a Department of Surgery at Guy's, a Department of Obstetrics has recently been started, with Mr. J. B. Blaikley as Director.

CHRISTMAS cards are now ready and may be obtained in the *Gazette* Office, price 6*s*. 6*d*. and 3*s*. 6*d*. per dozen, postage 6*d*. extra. To avoid disappointment early purchase is advisable.

Vertigo

By PHILIP READING, M.S., F.R.C.S.

An abstract of two Clinical Lectures delivered at Guy's Hospital.

"*A cruel distemper, a giddiness in my head that would not suffer me to write or think of anything, and of which I am now recovering.*"—(Jonathan Swift in a letter 1709.)

AN understanding of morbid processes must be based on a thorough knowledge of normal anatomy and physiology. Never forget Mr. Layton's precept:—"Ten minutes of anatomy every morning." This is particularly applicable to the study of labyrinthine disease. Our knowledge of the physiology of the inner ear is still imperfect, our understanding of the derangement of this mechanism is consequently also imperfect. Owing to lack of space in the pages of this *Gazette*, a discussion of the anatomy of the labyrinth and of the physiological principles underlying the maintenance and reflexes of postural tone has had to be omitted. Also, as part and parcel of this, reference to the static labyrinth has had to be deleted.

Let us pass to a consideration of the kinetic labyrinthine reflexes which preserve the animal's balance during movement and maintain its steady field of vision.

Flourens in 1842 showed that cutting across the semicircular canals of a pigeon produced inability to fly, forced movements of the head and eyes, and a general loss of equilibrium. Thirty years later, it was established that the canal system was an entero-ceptor system, that its stimulus came from within itself, and was produced by the movement of the contained endolymph.

Ewald's classical experiment on the pigeon must be remembered. He opened the semi-circular canals in two places. Through the hole further from the ampulla he introduced some amalgam, so as completely to block the lumen of the canal. Into the second hole he put the end of a thin tube. Injection of fluid through this caused a flow of endolymph towards the ampulla, and the bird's eyes turned in the direction of the endolymph flow. Suction of the fluid back from the canal reversed the endolymph flow and also the direction of the ocular movement.

Ewald's first law is absolutely fundamental to an understanding of the dynamics of the canal system:—

"Movement of the endolymph in a semicircular canal brings about a slow movement of the eyes in the direction of the endolymph flow."

Movement of the fluid in the superior canal of one side is brought about by such rotation of the head as must cause movement of the endolymph of the posterior vertical canal of the other labyrinth, as these two canals lie in the same place. The commonest eye movement is a rotary nystagmus, as a result of such stimulation. Movement of the endolymph in the horizontal canals gives a horizontal nystagmus. As no rotary stimuli can affect one horizontal canal without, in a state of health, affecting the other, the resulting nystagmus following rotation with the head erect is the result of the sum of the stimuli derived from the two canals. This brings us to Ewald's second law:—

"In the horizontal semi-circular canals, the current going towards the ampulla causes a stronger stimulus to be sent to the brain and hence to the eyes, than does a current away from the ampulla."

The recent work of Hallpike has thrown a certain amount of doubt on the correctness of this law. He suggests that, in certain diseased states, not only of the labyrinth, but also of the central nervous centres, there is a greater propensity (Nystagmus-Bereitschaft) for nystagmus to be produced in one direction rather than in another, and as a result of this, Ewald's second law may prove to be based on erroneous assumptions.

The clinical problem of labyrinthine destruction can be simplified if we regard the kinetic labyrinth as consisting of only one canal, the horizontal. In actual practice, this is the canal which is most frequently tested either by rotation or by caloric stimulation.

If we were flat fish living between two glass plates, we could move only in the horizontal plane. And we would then employ just such simplified labyrinths. No other movement would be possible for us, we could neither raise our heads nor turn over on to our backs for a little relaxation, perhaps a foretaste of things to come under the new Health Scheme.

Another way to picture the mechanism of labyrinthine function, again assuming that we are dealing only with the horizontal canal, is to think of a paddle steamer moving over a calm sea. If one paddle wheel (*i.e.* one labyrinth) were to stop working, the vessel would veer over to that side and turn in circles. If one labyrinth ceases to send out stimuli, the other labyrinth drives the head, the eyes and the body round to the injured side.

The effects of sudden labyrinthine destruction in man are :—

1. Slow movement of the eyes to the side of the lesion with a quick jerk back to the healthy side, *i.e.* nystagmus to the side of the intact labyrinth.

2. Falling of the body to the side of the inactive labyrinth.

3. Deviation of the outstretched hand to the side of the inactive labyrinth.

4. A sensation of vertigo, of falling to the sound side and of objects turning to the inactive side.

5. Pallor, nausea and vomiting.

These signs and symptoms are the same as occur after stimulation of one of two healthy labyrinths. Over-activity of one labyrinth gives the same results as under-activity of the other. Thus both labyrinths must be normally active. A reference to the analogy of the paddle steamer will help to make this clear. This analogy may be further elaborated. One paddle wheel has stopped and the ship continues to turn in a circle until the skipper can get to the wheel and put her back on a straight course. The rudder corrects the deviation from a straight course and incidentally conceals from the casual eye the ship's disability. That rudder is the re-education of the vestibular centres. In a few days they are learning to discount the stimuli being sent out from the one surviving labyrinth and are being influenced more by stimuli from the visual tract and from the entero-ceptor system of the muscles and joints of the body. In the higher mammals the vertigo grows gradually less, in a few weeks the nystagmus and the tendency to fall disappear. In lower animals, which are more dependent on their labyrinths, recovery is slower and often imperfect.

If, as sometimes happens in cerebro-spinal meningitis, both labyrinths are destroyed by a sudden bacterial invasion, the patient can, after some weeks, walk, run, dance and climb. Were he, however, to dive into deep water, he would drown. His eyes are blurred by the water and they tell him nothing of his position. The uniform pressure of the water on his trunk and limbs renders useless the entero-ceptor system of his joint and muscle sense. He becomes completely dis-orientated and no longer knows where to seek the surface.

Clinical labyrinthine tests are employed qualitatively to tell whether one or both labyrinths are alive, abnormally excitable or dead. Quantitative tests are employed to assess the relative excitability of each labyrinth. Unfortunately, we have no space here to consider these latter tests.

1. *Rotation test of Barany.* Stimulation of the vertical canals causes severe and unpleasant vertigo, and often vomiting. It is usual, therefore, to confine our investigations to the horizontal canals. The patient is seated in a revolving chair with the head bent forwards about 30 degrees from the true horizontal. This brings the horizontal canals parallel with the floor. After a few words of reassurance, the chair is rotated rapidly and smoothly in one direction for ten revolutions, taking about fifteen seconds to complete the turns. The chair is stopped abruptly and the amplitude and duration of the after-nystagmus are observed. Let us analyse what is happening inside the labyrinth. On beginning the turn, the endolymph lags behind the moving canal wall, and so there is a relative movement of the endolymph in a direction contrary to the general movement of the canal walls. This stimulates the hair cells of the ampulla and the eyes are swivelled back to the point from which the head was turned, with a rapid jerk in the direction of turning.

As soon as the inertia of the endolymph is overcome, the fluid will rotate at the same rate as the canal walls and there is no nystagmus, and no vertigo beyond that occasioned by the blurring of the visual fields (visual vertigo).

When the rotation of the head is suddenly stopped, the endolymph goes on circulating while the canal walls are stationary, and consequently the eyes are deviated in the direction of the rotation of the previous rotation of the head, with a quick jerk back to the side from which the head was turned.

After rotation to the right, the endolymph in the right ampulla is going away from the ampulla, the endolymph in the left canal is going towards the ampulla. As, according to Ewald's second law, the current towards the ampulla is the stronger stimulus, the after-nystagmus resulting from turning the patient to the right is made up of two thirds from the left and one third from the right. In other words, when we swing a patient to the right, the left canal is responsible for most of the after nystagmus. Applying this to the investigation of a patient suffering from vertigo, we may find that rotation to the right gives an after-nystagmus twice as long as rotation to the left, in other words the right labyrinth is inactive.

2. *Caloric test.* In syringing the external auditory meatus to remove wax or debris, you should take care to have the fluid at body temperature. If it is too hot or too cold, vertigo may be caused.

As you will remember from your physics, convection currents are set up, when the bottom of a test tube of water is warmed, and the warm fluid rises. When the top of the tube is cooled, the convection currents are reversed and the cool fluid sinks. The excitability of the labyrinth can be tested by laying the patient on his back, with the horizontal canal in the vertical position. When the external meatus is irrigated with cold water, there will be cooling of the tympanum and of the inner tympanic wall, of which the ampulla of the external canal forms a prominent landmark. Convections currents in the endolymph cause the fluid in the canal to sink. The eyes move slowly in the same direction, down towards the irrigated ear, and jerk quickly back towards the other ear. Syringing of the ear with cold water should normally give nystagmus directed to the other ear. Warm water will produce exactly the opposite reaction. Provided that the external auditory meatus is free from obstructions which might hinder the flow of the water up to the tympanic membrane, this is the most reliable way of ascertaining whether the labyrinth is alive or not.

3. *Fistula test.* Increase or decrease of pressure in the external auditory meatus occasionally causes vertigo. Sometimes this is found where there is no suspicion of aural disease and is then attributed, rightly or wrongly, to such causes as abnormal mobility of the foot plate of the stapes in the foramen ovale. In the presence of aural suppuration, a positive fistula test tells us one thing certainly, that the labyrinth is alive, and one thing probably, that there is an erosion of bone over some part of the labyrinth, which has exposed the membranous system to the influence of this change in pressure. The commonest site for such an erosion is over the torus of the external canal and over the promontory. It is almost a clinical repetition of Ewald's experiment on the canal of the pigeon.

4. *Galvanic test.* One electrode is applied to the mastoid process, the other is held in the hand. A galvanic current of 4 milliamps. or less is passed through the circuit and, if the anode is applied to the mastoid process, there is resultant nystagmus to the other ear with a tendency to fall to the side of the anode. Even if the tested labyrinth be completely inactive, a positive result will still be obtained so long as the vestibular nerve is intact.

Signs of labyrinthine dysfunction. 1. *Nystagmus.*

While most patients suffering from labyrinthine lesions show nystagmus, not all patients with nystagmus are suffering from labyrinthine disease. It is customary to consider nystagmus under three groups :—

Third Degree. Nystagmus is present no matter in what direction the eyes may be turned. When the eyes show a nystagmus to the right, even though they are turned strongly to the left, nystagmus of the third degree is present.

Second Degree. Nystagmus is present when the eyes are directed straight forwards. Nystagmus of the second and third degree indicate disease either of the labyrinth, of the eyes themselves or of the central nervous system :—

A. *In periphereal labyrinthine disease.* The characteristics of true labyrinthine vertigo are a slow movement to the side of the less active labyrinth, with a quick movement back to the other side. The movements are fine, regular and rapid, and the eyes move horizontally with a rotatory twist of the eyeball.

B. *In lesions of the vestibular centres in the lower pons and medulla.* This region of the brain stem may be affected by various diseases, tumours, disseminated sclerosis, syringo-bulbia, encephalitis and thrombosis of the posterior inferior cerebellar artery. The nystagmus may be of any type, but is occasionally vertical, which is never seen in spontaneous labyrinthine nystagmus. Also, such central nystagmus may be directed to the deaf ear, whereas in labyrinthitis, it is usually directed to the healthy ear. Tumours of the cerebrum may be accompanied by nystagmus.

C. *In ocular lesions.* Any lesion which prevents a sharp image falling on the fovea, may produce nystagmus. Blindness, congenital cataract, corneal scars may be responsible. Also, any circumstance which prevents adequate illumination of the field of vision may cause it, as, for instance, miners' nystagmus. Spasmus nutans, which might be described as a nystagmus of the whole head, occurs in babies who have been left for a long time in a dark room.

First Degree. End-Position Nystagmus. This is to be seen only when the eyes are directed strongly to the side to which the nystagmus is directed. It may be purely physiological, due to the over-strain imposed on normal muscles by the unusual position. It may indicate a slight pathological upset of the mechanics of the ocular muscles. In lesions of the vestibular system, looking in the direction of the quick component of a slight pre-existing nystagmus, will always accentuate the nystagmus. In a patient, who is recovering from a one-sided labyrinthine destruction, nystagmus of the third and second degree is present for the first few days, then, as compensation is established, only nystagmus of the first degree can be obtained. Finally, after about three weeks, not even this nystagmus can be elicited. The brain stem centres are however still in a state of preparedness to bring about nystagmus (Nystagmus-Bereitschaft).

Nystagmus-Bereitschaft. As a result of disease or injury of the labyrinth or of certain parts of the central nervous system, the vestibular and ocular centres are prepared to favour nystagmus in a certain direction. Let us take a concrete instance. A man has suffered death of the left labyrinth some three months ago. He has perfect compensation; no imbalance and no nystagmus are to be seen. If his left ear is douched with water of any temperature, he will show no signs of vestibular irritation, as this labyrinth is stone dead. If his right ear is douched with cold water, he will show a normal nystagmus to the left; if his right ear is douched with warm water, a normal nystagmus to the right. These are the normal responses of a healthy labyrinth. But, by using delicate quantitative methods, we can show that the duration of the nystagmus to the right is longer than that to the left. In other words, we find that irrigation with water at a temperature 7° C. above normal gives a nystagmus of longer duration than does irrigation with water at 7° C. below normal temperature (37° C.). The nystagmus is prolonged because the centres in the brain stem are prepared to favour nystagmus to the right. Nystagmus to the right indicates that the slow component, the vestibular component, is to the left, to the side of the destroyed labyrinth.

2. *Falling and Pointing Reactions.*

A unilateral labyrinthine lesion will cause falling and deviation of the limbs to the side of the lesion. This is due to the unopposed action of the other labyrinth. Lesions of the vestibular centres in the brain stem will cause similar symptoms. Falling and ataxia of the limbs is found in cerebellar lesions, though probably these signs are the result of pressure of the cerebellar tumour on the blood supply to the adjacent vestibular centres.

Any disease, which attacks one of the three great stabilizing systems of the body, the labyrinth, the visual tract and the muscle-joint enteroceptors, will cause imbalance of the body, but not necessarily will it cause vertigo. In tabes, a disease of the important muscle and joint enteroceptive system, the balance of the body is grossly upset, though it is unusual for the tabetic to suffer from true vertigo.

(To be concluded.)

A Case of Oliguria in the Puerperium

Presented by K. F. ANDERSON.

Case History.—Mrs. S., aged 41 years, was admitted to Guy's Hospital under Mr. Gibberd on July 21st, 1946. She had a living child delivered at her home with the aid of forceps at 12.15 p.m. on the same day, and two unsuccessful attempts had been made to express the retained placenta. Pituitrin, 1 c.c. had been given at 3.30 p.m., and it was estimated that approximately one pint of blood had been lost prior to admission at 4.30 p.m.

Previous Pregnancies.—One miscarriage 3 years ago, at 7 months.

Condition on admission.—The patient was pale and shocked, with a pulse of 156/min., of poor volume. The systolic blood pressure was 90 m.m.

On Examination at 4.30 p.m.—The placenta appeared to be in the vagina, and a further attempt at expression was made under gas and oxygen anæsthesia. This was unsuccessful, and it was noted that the patient passed a few minims of clear urine. The pulse remained at 156/min., and general measures for resuscitation were started.

Treatment and subsequent progress.—At 5 p.m., one pint of plasma was given intravenously, followed at 6 p.m. by one pint of blood, Group II A. The patient was cross-matched prior to administration. There was no complaint of pain during the transfusion, and the temperature remained normal throughout. At 6.45 p.m., the patient was seen by Mr. Gibberd, who prepared to remove the placenta manually, under general anæsthesia. Before proceeding it was found that the uterus was readily palpable, and the placenta was expelled easily and completely by Crédé's method. It was thought at the time that a contraction ring had been present in the uterus, following the effect of pituitrin on a hyperexcitable myometrium. This ring had presumably disappeared under the influence of morphia and rest.

22*nd July.*—General condition much improved. Pulse 80/min. Blood pressure 120/90. Temperature 98.0.

23*rd July.*—Despite a total fluid intake of 220 oz. in 24 hours, the patient passed only 4½ oz. of heavily blood-stained urine, giving a strongly positive guaiac reaction. The blood urea was 240 mg. /100 c.c. The Van den Bergh reaction, both direct and indirect, was negative. The following chart indicates the fluid intake and out-put in 24 hours, together with the blood-urea readings for the subsequent 9 days :—

Date	*Fluid intake in ozs.*	*Urinary output in ozs.*	*Blood Urea in mg./100 cc.*
23rd	220	4½ Blood	240
24th	94	3½ Blood	272
25th	93	3 No blood	340
26th	66	6 „	450
27th	77	19 „	452
28th	61	28++ „	—
29th	91	67++ „	450
30th	119	67+++ „	458
31st	67	100+++ „	—

Fluids were given throughout by intravenous drip and a certain quantity of 20 per cent. dextrose-saline by syringe. Alkalies were administered by mouth. In three samples of urine sent for examination the urea concentration was 0.35 per cent. 0.7 per cent. and 0.7 per cent. respectively On the 30th July, the patient became extremely confused and irrational, and clinical examination revealed scattered râles at both bases. Late in the evening of the 1st August, she suddenly became very dyspnœic and died at 8 p.m.

Autopsy Findings.—Respiratory System : Lungs only slightly œdematous. Trachea normal.

Spleen : Extremely friable. Typical "septic spleen."

Liver : Considerable enlargement with fatty change.

Kidneys: Macroscopically normal. No evidence of cortical necrosis.

Endocrine Glands: No abnormality detected.

Uterus: Large, greenish necrotic area involving the whole of the lower segment. Afferent and efferent vessels patent.

Report on Sections.—(1) Uterus shows replacement of endometrium by fibrino-purulent exudate containing Gram positive cocci.

(2) Liver: Postmortem changes only.

(3) Kidneys: No obvious abnormality.

(4) Thyroid: Severe and diffuse purulent inflammation.

Anatomical Diagnosis.—Postpartum infective endometritis. Suppurative thyroiditis.

Discussion.—At the onset of oliguria, the clinical diagnosis seemed to rest between some curtailment of renal function following the transfusion of stored blood, or the somewhat rare condition of bilateral renal cortical necrosis. The latter condition always produces obvious macroscopic and microscopic changes in both kidneys, with necrosis of many glomeruli. At autopsy there was no obvious abnormality in either kidney, and in the absence of any microscopic findings to indicate gross intravascular hæmolysis, it is suggested that the case under discussion falls within the group of "late transfusion reactions." Trueta and his co-workers have shown radiographically that by injecting opaque materials into the renal arteries of animals, appropriate nerve stimulation will divert the renal blood-flow from its commonly accepted course. As a result of this, the cortex may be wholly or partly deprived of its blood supply. Trueta stresses the importance of this mechanism whereby a temporary cortical ischæmia may be produced without arrest of renal circulation. He suggests that the nerve stimulation could be produced centrally or peripherally by a variety of noxious agents, and that the picture seen in many loosely related syndromes (sulphonamide kidney, transfusion kidney and the crush syndrome) is a result of a defence device by which the cortex of the kidney is excluded from the circulating toxin and thus protected. These theories furnish some possible mechanism for the production of an oliguria in the case described, though the source of nervous stimulation is extremely debatable.

Summary.—A case of oliguria in the puerperium is described, and the possible mechanism of production briefly discussed in the light of recent work on vascular phenomena within the kidney.

I am indebted to Mr. G. F. Gibberd for permission to publish the details of this case, and to Dr. S. J. de Navasquez for access to the pathology reports.

REFERENCES.

Gibberd, G. F. "Text-book of Midwifery." 3rd Edn. Trueta, J.; Barclay, A. E.; Daniel, P.; Franklin, K. J.; Pritchard, M. L. *The Lancet*, August 17th, 1946, p. 273.

The Department of Surgery

WE are indebted to the Director, Mr. H. J. B. Atkins, who has been kind enough to grant us an interview and tell us of the proposals and plans for the new Department of Surgery to which we have referred in Passim.

THE LAYOUT AND ESTABLISHMENT.

The whole of the surgical block forms the department and all the surgical staff are members of it. At the earliest opportunity it is proposed to have premises wherein the special work of the department will be carried out. The first floor of Guy's House will be taken over and along the main corridor running from south to north arrangements will be as follows:—

The present anæsthetic room will become a workshop. Theatre I and its preparation room will provide rooms for demonstrations, clinico-pathological meetings and for discussions. A cinema will also be available. Professor Nicholson's old room becomes the Director's office, and his secretary will occupy the adjacent room, previously known as Sister Radium's.

Theatres II and III are to be modernised, the radiators and lighting being made flush with the wall. Glass-screened balconies of a semi-circular shape are to be erected and a microphone installed to allow the surgeon to comment to his audience.

Swing-doors will be provided in the surgical block wherever they are necessary to maintain it free of dust and it is hoped that more beds will become available in the east wing.

The possibility of a central supply store is being considered and this may be located on the second floor in what remains of Naaman ward. From it all sterilised apparatus whether required by the wards or theatres would be obtained.

DUTIES OF THE DIRECTOR.

The Director will act as surgical sub-dean, being responsible for the co-ordination and policy of all undergraduate and post-graduate teaching. He will arrange the clinical lectures and the time-tables. His duties will entail the supervision of the training of registrars and housemen and the organisation of demonstration operations. In this last connection it is hoped, in alternate months, to invite surgeons from elsewhere to come and perform their own operations, while in the intervening months our own surgeons will do theirs.

The Director will encourage research into surgical matters and co-ordinate the facilities available for it. In addition, he will act as editorial adviser on surgical papers emanating from the hospital.

He will receive and entertain surgical visitors and will be expected to visit clinics outside.

The equipment of the surgical block and of surgical out-patients is the Director's concern.

THE FIRST STAGE.

As may be expected, it will not prove possible to fulfil all the proposals from the beginning but certain activities will start at once. These will include: clinico-pathological meetings, rounds for old Guy's men and post-graduates, demonstrations lasting over periods of a week and instruction in post-graduate surgery.

Arrangements will be announced, from time to time, in the *Gazette*. The first post-graduate round will be held in the Department on Saturday, November 9th. It will begin at 10 o'clock and end at noon.

Correspondence

Women Students

SIR,—In your "Passim" of the 12th October you refer to the advent of women students in the next session as "a very solemn subject—a tragedy" and to them as "interlopers." Even allowing for editorial journalese and a spirit of levity, which latter is not apparent, it is unfortunate that in a special number of the *Gazette* devoted largely to addresses of welcome, the future women students of the School should be singled out as unwelcome intruders.

In the same "Passim" you refer also to the "*impertinent* encroachments" of biologists in the realm of Anatomy. Without entering into the controversial nature of this statement, it is presumably not merely a coincidence that a very distinguished biologist has recently been appointed to the Chair of Anatomy in another School of the University to which Guy's Hospital Medical School also belongs.

In an age in which, as you rightly say, courtesy and good manners are declining, it is particularly to be regretted that such irresponsible language should appear, not for the first time, in the pages of the *Gazette*, the official organ of the Medical School and Hospital, where it is likely to be misunderstood by newcomers to Guy's.

Yours faithfully,

B. J. RICKARD.

Department of Biology,
Guy's Hospital Medical School.

Passim

SIR,—I read with interest " Passim " of your issue of October 26th, 1946, and noted the remarks about the unwillingness of the newly-qualified to admit their desire to enter General Practice.

One realises only too well their difficulties as regards buying practices, and houses, and the uncertainty that has arisen as to the future ; but surely for many years the G.P. has been looked upon by some as " the lowest form of Medical Life."

Is it not now time, in view of the promised New Era in Social Security, that the position of the G.P. was defined ?

Surely he is the mainspring around which all medicine should revolve.

In recent years vigorous efforts have been made to pass over to others his work, such as by School and Municipal Clinics, by Factory Surgeons and Vaccination Officers, and by the Out-Patient Departments of some Hospitals. With this new era of Medicine from " the Cradle to the Grave," surely the G.P. is the man to handle and direct it.

He sees the child at birth (or should) and, for the old, it usually falls to his lot to sign the death certificate. *Therefore the responsibility of working the scheme should be his.*

The School Doctor, the Health Authorities and Specialist, should be at his patients' service under his guidance.

The G.P. now plays an important part in the Social life of the community, and the Medical Profession should see to it that, in the future, the right type of man is adequately trained for this very varied job.

Yours, etc.,

J. R. F. POPPLEWELL,
General Practitioner.

Keneydon, Whittlesey,
Nr. Peterborough.

General Practice.

SIR,—You do well to bring the claims of general practice to the notice of those of your readers who have to face the difficult task of deciding on their future work in these uncertain times. They can only arrive at a satisfactory conclusion by disregarding the imponderables and addressing themselves to a dispassionate analysis of their particular tastes and talents.

It seems probable that general practice will give greater scope for initiative in the future era of state medicine than that which will be enjoyed by the specialists who will be effectively tied down in their state hospitals. The people will not change their character overnight and readily forego that intimate and peculiar relationship which exists between a family doctor and his patient and which cannot possibly survive in a service which is arranged on a salaried, or capitation, basis. Panel, or National Health Insurance practice, would have been a dismal failure if it had not been worked as an adjunct of private practice and, in fact, most doctors have regarded this part of their work very much in the same light as consultants have regarded their hospital duties.

Unfortunately the student can learn nothing of the general practitioner's life from his teachers who have no direct knowledge of it and he will probably not have been impressed by the contacts which he has made with general practitioners during the performance of his house appointments. As a locum tenens, or an assistant, he may gain some appreciation of the routine and difficulties of general practice, but he will savour little of its satisfaction. To know the joy of general practice he must have a practice of his own and patients of his own who rely upon him and give him their confidence. When he has had the pleasure of this experience for some time he will find, probably very much to his surprise, that he is beginning to feel sorry for his friends who have decided to become specialists. They will never be able to establish that friendly and personal relationship with their patients which can only be secured by an intimate knowledge of the patient, of his family and of his home. A physician once told me that the part of his work he enjoyed most was looking after doctors and their families. It was the nearest he ever came to being a general practitioner.

The doctor who goes into general practice before the introduction of state medicine will be free to choose the place where he wishes to live according to his tastes. If he

buys a practice or a partnership there can surely be no reasonable doubt that he will receive the same terms of compensation as those of us who are already established. That those terms must be fair and reasonable is inevitable. If they are not it is quite certain that there will never be a state medical service as far as general practitioners are concerned. The recent settlement secured by the panel practitioners should reassure anyone who has doubts in this respect. The prospective practitioner will, of course, need a motor car, but it should not be necessary for him to buy a house. In fact he would be unwise to do so. It would be more prudent to rent a furnished house or even live in rooms until prices become more reasonable.

The intending general practitioner will require some guidance as to the form of post graduate study most suited to his future requirements. He will find a good knowledge of medical diagnosis, of children's diseases, of skin diseases and sound training in midwifery of great advantage. The proposal to confine the practice of midwifery to specialists and midwives seems unlikely to succeed. In most areas, as for example the one in which I live, such a service is already available, but many of the women, even those of limited means, elect to be looked after by their family doctors in their confinements. For this reason the beginner will be wise to join a partnership where he will get the training and experience in midwifery which he almost certainly did not enjoy as a medical student.

Your suggestion that there shall be a return to the old apprenticeship system will commend itself to many doctors as also will your proposal that general practitioners should share in the training of medical students. What could be more reasonable than that the art of domiciliary practice should be taught by those who have learned its lessons and experienced its difficulties ?

I am, etc.,

36, Amersham Road,
High Wycombe,
Bucks.

DAVID ELLIS.

Mushroom Poisoning in a Diabetic

SIR,—I read the lucid account by Village Doctor of mushroom poisoning in his wife with diabetes mellitus with great interest, but consider that a criticism of his treatment should not pass unmentioned.

He states that the patient was quite unable to take food and in the circumstances insulin was withheld. Authorities on Diabetes state that in such circumstances half the usual doses of insulin should be given at first and adjusted later. Most of the cases of diabetic coma seen to-day are caused by withholding all insulin in diabetic patients suddenly unable to eat by reason of illness. I, therefore, would say that the blood and urine tests would probably have been more satisfactory if some insulin had been given. Also, in this case, there would have been less danger of severe liver-cell degeneration if insulin had been given, for then the liver cells would have been able to utilise glucose.

H.M.S.T. draws a distinction between the ketosis of diabetes and the acetonuria of starvation. Both are alike ; in both sugar cannot be utilised, there being a lack of insulin in the former and a lack of sugar in the latter. His patient belongs to the former.

Incidentally this reduced dosage of insulin was recommended during the Blitz to be taken by diabetic people the morning after being bombed out, if they could not obtain anything to eat immediately.

I am, etc.,

569, Upper Richmond Road,
Richmond, Surrey.

R. S. ELLIS-BROWN.

"Advertising"

SIR,—Perhaps it may be news to Mr. J. N. O'Rafferty that makers of proprietary remedies are required by law to state their *exact* composition on the package. The composition of Curicones, as given by the maker on each package is : Sulphur 19.7%, Sodii bicarb. 5.6%, Taraxacum 3.5%, Guaiacum Resin 2.1%, Acid Acetylsalicylic 3.5%, Sodii Benzoate 1.4%, Casein 3.5%, Ginger 0.7%, and Excipient to 100%.

An example of polypharmacy which rivals in composition the fabulous "Mithridatium" or *Confectis Damocratis* (see "Materia Medica—And All That," Guy's *Gazette*, page 170, about 1936 or 7). No wonder that the uric acid crystals which one sees in the little pictures of Curicone advertisements (before taking) take flight for very fear of such a formidable host. What a difference from the once-famous "Elasto" which claimed to cure varicose veins, and which, as far as my examination was concerned, contained nothing but Lactose! But then I have never seen a case of gout or rheumatism cured by Curicones nor of varicose veins cured by Elasto; although at one time I spent quite a lot of money investigating the claims of proprietary remedies.

I am, etc.,

ÆSCULAPIUS.

Apprenticeship

SIR,—With reference to your note in "Passim" of October 26th, there is no doubt that the average young newly-qualified doctor will be horrified to learn how very unsophisticated most of the *genus* are, when they stand on their own feet and carry their own responsibility for the first time. For one thing, it is very rare to find one who really knows how to write a prescription. A common failing is to order proprietary remedies, of whose composition they are blissfully ignorant, or to prescribe stock mixtures of the hospital pharmacopœia without indicating on the prescription the particular pharmacopœia referred to—and I am not referring only to Guy's men. I remember a newly fledged graduate looking out for me for a few days, and when I got back half the chemists in the place were ringing me up for a week, to know "what Dr. X. wants when he orders m.m. and ms."—or whatever the stock mixture happened to be. How far this may be due to laziness, bad habit or (as I suspect) bad teaching, is not for me to say. Few seem to have an accurate knowledge of doses.

The British Pharmacopœia contains sufficient preparations for the effective medicinal treatment of any illness or disease if the prescriber knows his job. Another fault is prescribing incompatibles which result in horrible looking mixtures that will hardly pour from a bottle.

It is a disgraceful thing for a doctor to learn his materia medica and therapeutics from the folders distributed by manufacturing chemists, many of whose productions are compounded of ordinary drugs of the pharmacopœia and sold under fancy names at fabulous prices. Why such preparations should be thought to possess any magical properties, goodness only knows. Pluriglandular preparations seem to be very popular. All of them contain a small amount of thyroid, the only active ingredient when taken *per os*. Thus is encouraged the sale of the offal of Chicago slaughter yards at fabulous prices—as I think was once said by J. L. Witts. Instruction by a G.P. would do a world of good.

I am, etc.,

"STANLEY."

Hospital Information, etc.

Notices

APPOINTMENTS

At a meeting of the Court of Governors of Guy's Hospital, held on October 7th, 1946, the following appointments were made to the Visiting Staff of the Hospital:—

Assistant Physician: Dr. C. G. Baker, O.B.E., M.D., M.R.C.P.

Assistant Surgeon: Guy Blackburn, Esq., M.B.E., M.Ch., F.R.C.S., of Cambridge University and St. Bartholomew's Hospital.

Director of the Department of Child Health and Physician to the Children's Department: Dr. P. R. Evans, M.D., M.Sc., F.R.C.P., of Manchester University, at present Physician for Children, King's College Hospital.

Director of the Department of Diagnostic Radiology: Dr. T. H. Hills, M.B., B.S., D.M.R.E.

Physician in Charge of the Physiotherapy Department: Dr. E. J. Crisp, M.B., B.Ch.

Assistant Dental Surgeon: H. H. Kenshole, Esq., D.S.O., T.D., M.R.C.S., L.R.C.P., L.D.S.

Assistant Dental Surgeon in the Children's Department: K. E. Pringle, Esq., L.D.S., R.C.S.

DETAILS OF SCHOLARSHIPS.

The Swedish Government is offering, through the Swedish Institute for Cultural Relations, a scholarship for a British student to study for one year at a Swedish University or similar Institution. The value of the scholarship is 2,250 Swedish Crowns plus a travelling grant of 350 Swedish Crowns, that is to say, approximately £175 in all. The Swedish Institute for Cultural Relations is offering two scholarships for similar purposes, each of the value of 2,750 Swedish Crowns, or roughly £180.

The Swedish academic year starts on the first of September and is divided into two terms: September 1st–December 15th and January 15th–June 1st, respectively. The suggestion is that the holders of the scholarships should start their work at the beginning of the spring term 1947, *i.e.* about the middle of January. Therefore, the applications ought to be received at the Swedish Institute not later than November 1st. Applications should be made in writing to The Dean, Guy's Hospital Medical School, not later than Tuesday, October 29th.

Swedish Universities are not residential. The Scholarships are supposed to cover, if not all, at least the major part of the cost of a year's study in Sweden, board and lodging and university fee.

GUY'S INNOMINATE CLUB.

The 12th Reunion Dinner was held at the Trocadero Restaurant on Friday, 18th October. C. L. Worthington, the Chairman, and 39 other members were present. The reunion of so many old friends was a great success. J. H. M. Lloyd was elected Chairman for next year.

ASSOCIATION FOOTBALL CLUB.

The Association Football Club is in urgent need of Guy's shirts.

It will be greatly appreciated, therefore, if all those old soccer players who have shirts which are not needed will kindly offer them to the club.

H. R. C. RICHES,
Captain A.F.C.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

ADDITIONAL F.R.C.S. EXAMINATIONS.

There will be an additional Primary F.R.C.S. Examination to be held in London in January, 1947, open to all eligible candidates, except those unsuccessful candidates who may be "Referred" for six months in the October examination.

The papers will be written on Wednesday and Thursday, January 22nd and 23rd, and the oral part of the examination will begin on Monday, January 27th.

Applications for admission to the examination, accompanied by the full amount of the fee (£8 8*s*.) may be submitted to the Director of Examinations after November, 1946, and cannot be accepted later than WEDNESDAY, JANUARY 1ST, 1947.

There will also be an additional Final F.R.C.S. Examination to be held in London in February, 1947, open to all eligible candidates, except those unsuccessful candidates who may be "Referred" for six months in the November examination.

The paper will be written on Thursday, February 20th, and the clinical and oral parts of the examination will begin on Monday, February 24th.

Applications for admission to the examination, accompanied by the full amount of the fee (£15 15*s*.) may be submitted to the Director of Examinations after November, 1946, and cannot be accepted later than THURSDAY, JANUARY 30TH, 1947.

Copies of the Regulations for the F.R.C.S. and forms of application may be obtained, post free, from the address below.

(Signed) HORACE H. REW,
Director of Examinations,
Royal College of Surgeons of England.

Examination Hall,
Queen Square,
London, W.C.1.
October, 1946.

FINAL F.R.C.S. COURSE.

The next Final F.R.C.S. Course will begin on February 17th, 1947, and any Guy's men who wish to attend should send in their names to the Medical School Office not later than Monday, November 18th. The Course will extend over a period of ten weeks and the fee for Guy's men will be £25.

J. H. E. WINSTON,
Secretary.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

BRADSHAW LECTURE.

The Bradshaw Lecture will be delivered at the College, Lincoln's Inn Fields, W.C.2, on Thursday, November 14th, 1946, at 5 p.m., by Sir Heneage Ogilvie, K.B.E., F.R.C.S., Vice-President of the College, on Surgical Handicraft. The Lecture is open to Medical Practitioners and Advanced Students. Tea will be served before the Lecture from 4.30 p.m.

W. F. DAVIS,
Assistant Secretary.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

The next EXAMINATION for the MEMBERSHIP will commence on *Monday, 30th December*, 1946.

Prospective candidates are asked to note that entries accompanied by the certificates and testimonials required by the Bye-Laws must reach the College not later than first post on *Monday, 2nd December*, 1946.

Candidates who propose to submit Published Work under the regulations are required to give twenty-eight days' notice, and should apply in writing to the Registrar, without delay, for detailed instructions as to the procedure they should follow. The last day for receiving completed entries for Published Work is also *Monday, 2nd December*, 1946.

H. E. A. BOLDERO, D.M.,
Registrar.

Pall Mall East,
London, S.W.1.

GUY'S THEATRE CLUB.

"Hay Fever" will be presented in the Physiology Theatre at 7.45 p.m. on :—

Tuesday, 10th December.
Wednesday, 11th December.
Thursday, 12th December.
Friday, 13th December.
Saturday, 14th December.
(And at 2.30 p.m.).

Admission free. All seats bookable. There will be a collection, any proceeds in excess of cost will be given to the Hospital Wireless Fund. Tickets on application to Hon. Sec., Theatre Club, Guy's Hospital, S.E.1.

Many missed our last production because all seats were booked, and some ticket holders failed to occupy their seats. Should any ticket-holder find he is unable to come will he please return his ticket in good time for re-issue, or pass it on to someone who will use it. Empty seats are good neither for the players nor for the collection.

One last appeal. Please arrive on time; we often have had to start late because our audience has not arrived!

JOHN G. STEBBING,
Hon. Sec., Guy's Theatre Club.

OUT-PATIENTS CHILDREN'S TEA PARTY.

Readers will be pleased to hear that this Party will be held again in the Out-Patient's Hall on Christmas Eve. It is hoped to invite about 250 children between the ages of 6 and 10 years—all of whom have been patients during the past year. Gifts or donations will be welcome and should be addressed to Sister, Out-Patients, Guy's Hospital, S.E.1, marked "Tea Fund."

BLUES' COMMITTEE.

At a recent meeting of the Blues Committee the following awards were made :—

Cricket.

Full Blue.	*Half-Blue.*
I. A. H. Munro	G. P. Billingham
A. M. Platt	R. Harvard Davis
J. D. Williams	P. S. Holmes
	R. G. Nicholson
	H. M. C. O'Driscoll

Tennis.

E. J. Filose	P. S. Carton-Kelly
	M. Hume
	I. Kelsey Fry

Boxing.

S. F. A. Westgate	M. Harber
	M. Mason
	A. McLaughlin
	N. M. Porter
	R. D. Walsh

Squash.

R. Freeman
P. S. Carton-Kelly

Pass List

CONJOINT BOARD.

FINAL EXAMINATION.

L.R.C.P., M.R.C.S.

October, 1946.

Pathology.

C. H. J. Van Aswegan	J. G. Stebbing
J. L. Hardman	D. Walker
R. H. N. Long	W. B. Webb

Medicine.

G. F. Barnes	*J. L. Jenman
*D. W. J. Cullingford	D. Walker
H. Herbert	W. B. Webb

Surgery.

*L. W. Bowen	L. J. Evered
R. W. Doy	P. Read

Midwifery.

*I. A. Blackmore	C. J. Roux
S. J. Harris	E. P. H. Shortt
*J. L. Jenman	S. G. A. Shute
P. Read	

UNIVERSITY OF CAMBRIDGE.

FIRST M.B. EXAMINATION.

PART III.—Elementary Biology.

October, 1946.

J. W. B. Dalgleish

DEGREES OF BATCHELOR OF MEDICINE AND BATCHELOR OF SURGERY.

Special and Clinical Pathology.

October, 1946.

R. A. Griffiths	D. C. Turk
M. S. Kay	J. H. B. Yule
B. V. McEvedy	

Forensic Medicine and Public Health.

October, 1946.

R. Harvard Davis	B. V. McEvedy
I. Kelsey Fry	A. G. Parks
R. A. Griffiths	D. C. Turk
M. S. Kay	J. H. B. Yule

Pharmacology and Principles of Therapeutics.

A. C. M. Mann.

UNIVERSITY OF LONDON.

EXAMINATION FOR THE EXTERNAL DIPLOMA IN CLINICAL PATHOLOGY.

October, 1946.

W. P. Stamm, M.B., B.S.

Change of Address

J. Bates, M.R.C.P., D.C.H., D.P.M., County Hospital, Farnborough, Kent.

J. B. Blaikley, F.R.C.S., F.R.C.O.G., "Glencairn," 125, Burdon Lane, Belmont, Sutton, Surrey. (Tel. : Vigilant 5621.)

W. G. Cross, M.B., B.S., B.D.S., Dept. of Preventive Dentistry, Dental School, Guy's Hospital, S.E.1, and "Kingsmead," Limpsfield, Surrey.

R. Finney, Surg.-Lt. R.N.V.R., H.M.S. "Sultan," Blakang Mati, Singapore.

P. Forgacs, M.D., M.R.C.P., 24, Holland Park Gardens, London, W.14.

H. P. Guerrier, M.B., B.S., 96, Normandy Avenue, Barnet, Herts. (Tel. : Barnet 6008.)

J. G. Hancock, B.D.S., L.D.S., 19, Harcourt House, 19, Cavendish Square, W.1. (Tel. : Langham 2425.)

Appointments

Dr. Neville Lloyd, M.R.C.P., has been appointed Chief Medical Officer, Ministry of Supply.

J. Bates, M.R.C.P., D.C.H., D.P.M., Assistant Physician, The County Hospital, Farnborough.

Births

COCKBURN.—On October 19th, 1946, at Guy's Hospital, to Dorothy, wife of Dr. H. V. Cockburn—a son.

DIMOCK.—On October 30th, 1946, in East Grinstead, to Betty, wife of J. R. Dimock, L.D.S.—a daughter.

Marriages

ALLEN—BOLINGBROKE.—On October 7th, 1946, in Salisbury Cathedral, S. Rhodesia, Ernest Allen, L.D.S., of Hull, to Peggy Elizabeth Bolingbroke, of Chelmsford, Essex.

HOUSDEN—JONES.—On October 12th, 1946, at Birkenhead, Charles Henry Housden, L.D.S., R.C.S., to Pamela Bray-Jones, widow of F/O. Ronald A. Jones and daughter of Mr. and Mrs. Philip G. Capon.

Deaths

FELIX-JONES.—On October 21st, 1946, at his residence, "Firfield," 7, Surrey Road, Bournemouth, Frederick Felix-Jones, M.R.C.S., D.P.H., in his 91st year.

LAMB.—On October 15th, 1946, suddenly, at Shaugh Prior, Devon, Charles John Lamb, L.D.S., R.C.S. late of Devonport).

EDS. { R.T.H. D.H.F.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LX No. 1522 *23rd November 1946* *Ninepence*

PASSIM

LONDON fogs, like London policemen, are famous the world over. Authors of detective stories owe much to those dirty November nights with "the yellow fog that rubs its back upon the window-panes," for do they not so often provide the backcloth for the juiciest murders in fiction ? There must be many people whose visual picture of this great metropolis consists of obscure, shadowy streets where silent figures suddenly appear out of the misty darkness and cough their way into pubs, while round the corner plays the eternal barrel-organ.

American script writers go even further and provide a Cockney who, to complete this London picture (all in glorious technicolour by kind permission of Natalie Kalmus), will wear the appropriate clothes and may even say "Cor Blimey ! ", with a Brooklyn accent of course.

Yet no matter how hard these outside artists try, they always fail to capture that atmosphere that is so much a part of this city. The yellow lights with their reflections winking on wet pavements, the muffled sound of traffic, and those eerie river noises which creep up out of the blackness are not for reproduction by the casual observer. The mumbled talk of people on those nights when little puffs of steam mark every word they say, is a language of its own whose accents cannot be acquired by a mere perusal of the works of Charles Dickens.

The area round this hospital is famous and full of local colour. Comparatively few visitors know this and perhaps that is just as well. It's a dirty part of London, where the numerous alleyways were once haunted by razor gangs and the lone traveller trod warily through the shadows of Klink Street or got lost in that maze of dark passages that form the way to the Anchor. We who know the Borough are fond of it and know its people to be warm-hearted and generous, capable of tremendous courage and possessing a unique sense of humour. We suspect that they, in their turn, are proud of their hospital and those of us who have been "on the district" were impressed by their sincere gratitude. We have also seen some of the hovels they live in, but as that side of their life doesn't make pleasant reading or beautiful pictures, it doesn't find its way on to the glorious cinema screen.

Guy's men and women who are away from their hospital must have vivid memories of the London Bridge district and so will be able to imagine the scene now as shop windows display brighter colours and urchins with dirty noses pressed against the glass make fabulous choices of what they want. A gayer, warmer influence pervades the atmosphere as December approaches and the Borough prepares for Christmas.

PSYCHOLOGICAL medicine is progressing by leaps and bounds. We have had electric currents passed through our brains, overdoses of insulin injected into our blood-stream, egg-whisks whirled about in our frontal lobes, while the ticking of a metronome has lulled us into such somniferous states that daring answers have been given to even more daring questions and we can no longer call our minds our own. What progress ! What next ?

The latest psychiatric enterprise sets a new fashion in prison reform and consists of a home from home for naughty citizens. How attractive it sounds ! "Come to Tortworth Court and forget those nasty thoughts about the old lady you strangled in Shepherd's Bush. After all you probably only did it because your father was a

drunkard and you've fallen in love with your rocking-horse ! Here, at the restful reformatory set amidst acres of beautiful park-land, tranquillity of mind is assured and *ill-placed sulci are smoothed out by kindness.* If you want to leave and don't mind a scramble through a rambler, you're free to go ! "

Civilisation is on the march and humanity is taking a hand. We foresee such schemes extended greatly during the next few years and perhaps, at a later date, families will be asked to entertain crinimals, just as they were asked to entertain allied troops. A homely atmosphere is a factor whose importance is being stressed more and more in the treatment of certain mental disorders, that is provided it is the atmosphere of the right sort of home. The necessity for the co-operation of the patient is obvious in the handling of any disease and, except for dealing with certain hysterical disorders, bullying is, for the most part, to be deprecated.

There are drawbacks, however, for difficulties are bound to arise. Imagine the embarrassment of the hostess when, in the middle of her tea-party, the guest of honour, suffering from a mental set-back, assaults the maid or knifes his neighbour. Similarly one may visualise the notorious guest shamefacedly replacing a silver ash-tray while explaining, " I'm really most terribly sorry. Please excuse me but I had one of my turns, you know. By the way, I've just shot the gardener ! "

This sort of strength through joy therapy is all very well, but we must not carry it too far and, while believing wholeheartedly in the innate goodness of our fellow-men—even those who have erred from the straight and narrow, we, at anyrate, are two who intend to continue locking our doors at night.

REGRETFULLY we say " Au revoir " to Mr. Philip Reading who, after a very short stay with us, must leave for the Services. We wish him good luck and hope to see him back at Guy's as soon as possible.

WE congratulate Dr. T. Hills on his appointment as Director of the Department of Radiology at Guy's Hospital. May we hopefully anticipate, with his continued presence amongst us, the early return of the annual Residents' Play ?

Obituary

CAPT. D. ROSENBERG, M.R.C.S., R.A.M.C.

DONALD ROSENBERG, only child of Mr. and Mrs. A. Rosenberg, was educated at Raine's Foundation School and entered Guy's in October, 1938, where he qualified in July, 1943. After holding House Appointments at The Royal Surrey Hospital for six months, he joined the Army and saw service in the Burma campaign during which he was wounded, having sustained a penetrating wound of his chest. He recovered from this and took over the duties of running a Convalescent Depot, which he held for the past nine months.

In January, 1946, the *British Medical Journal* published a letter of his, drawing attention to the Leprosy problem in India and pointing out the difficulties under which this disease is treated out there and suggesting stronger authoritative control of the large numbers of infected people who wander about amongst the population, also advising the use of suitable propaganda to enlighten the general public.

To all those who knew him intimately " Donnie " will perhaps be most remembered for his wonderful sense of humour and his astounding ability to draw caricature portraits of teachers and students. He possessed a very sensitive nature, which gave to him that rare ability, so valuable to a doctor, of understanding and feeling with emotion and yet without effort the suffering of the sick.

In September, 1945, he married Sister Frances Kavanagh Q.A.I.M.N.S. in India. They first met in 1939 when she was training at Guy's P.T.S. in Tunbridge Wells.

He died on October 14th, 1946, at the early age of 26, having contracted Typhus following the successful treatment of a very severe case of this disease in his care.

J.P.I.R.

Vertigo

By PHILIP READING, M.S., F.R.C.S.

An abstract of two Clinical Lectures delivered at Guy's Hospital.

(*Concluded*)

A patient complains of giddiness. He may find it extremely difficult to analyse his symptoms accurately. The most he can volunteer may be :—"Everything goes far-away, I feel light-headed and go dizzy." Cross-examination is essential to rule out a simple vaso-motor attack, which is often described as vertigo. Any condition, physiological or pathological, which interferes with the circulation of blood to the brain, may bring about such a transient attack of faintness. In investigating a case of vertigo, we must first find out if the patient has really suffered from vertigo, or from some syncopal attack.

History.—1, *of vertigo.*

(*a*) The giddiness is constant, and is growing worse over a period of some weeks or months. This suggests that the cause lies probably in the brain stem rather than in the labyrinth.

(*b*) There are recurring spells of vertigo, which may grow worse with each fresh attack. Between attacks, the patient is free from vertigo, but sharp turning of the head may bring on momentary unsteadiness. Such a history is often obtained in Menière's syndrome, in new growths of the cerebello-pontine angle and in some cases of chronic mastoiditis.

(*c*) The patient has one attack of vertigo, intense at the onset, but gradually growing less over a period of two or three weeks, until he is eventually entirely clear of the symptom. This history, in the presence of a chronic otorrhœa, suggests that the labyrinth has been invaded by infection and has been destroyed. The gradually lessening vertigo is due to the re-education of his vestibular nuclei, so that they learn to compensate the stimuli sent out by the normal, but unopposed side.

2, *of hearing.*

Labyrinthine disease usually is associated with changes in the hearing, which often point the way to a correct diagnosis. The total deafness of the dead labyrinth, the tinnitus of Menière's disease, the upper tone loss in lesions of the cochlea or cochlear nerve, all these are valuable signboards.

3, *of vegetative symptoms.*

Vertigo is attended by pallor, nausea and vomiting. These symptoms may be so marked as occasionally to obscure the clinical picture. Not a few patients have been treated for a "gastric upset" when in reality they were suffering from suppurative labyrinthitis.

The causes of labyrinthine vertigo and their treatment.

Physiological. Sea-sickness is partly labyrinthine and partly ocular in origin. The visceral effects of labyrinthine stimulation are much in evidence. Symptomatic treatment of this and other vertigoes consists of sedation, attempts to reduce the action of the para-sympathetic system and to increase that of the sympathetic system.

Sedatives commonly employed are :—Pheno-barbital gr. ½ three or four times daily and Chloretone 0.3 gram twice daily. Tinct. Belladonnæ ♏ 20 twice daily will help to restrain the para-sympathetic, while Amphetamine sulphate 10 mgm., repeated in six hours, stimulates the sympathetic, and so helps to stop the vomiting.

Traumatic. A rough division of these patients into two groups may be made. First, those who have symptoms of a post-concussional lesion of the brain, without demonstrable injury of the inner ear. Vertigo, with or without nystagmus, is one of the common symptoms of such patients. Testing may show aberrations of the vestibular system, although the acuity of the hearing is normal.

The second group suffers from so-called "concussion" of the inner ear together with and often over-shadowed by the symptoms of contusion of the brain. The hearing loss and tinnitus are features which suggest that there is damage to the inner ear. Injury to the inner ear from blast generally shows itself, shortly after the accident, by nystagmus, and, permanently, by reduction of the upper tone limit.

Toxic. According to Wright, endogenous toxins from foci of infection may cause vestibular dysfunction. Of exogenous toxins, the action of alcohol is best known to most people, though other drugs, such as quinine and the salicylates, are also sometimes responsible.

Infective. Pyogenic.

(*a*) *Para-otitis, circum-scribed labyrinthitis.* The former name is the more accurate, the second gives a false conception of the pathology of the disease. It is not a localised infection of the labyrinth, but a local infection of the surrounding petrous, which induces an abnormal excitability in an otherwise healthy labyrinth.

Into this catagory falls the so-called "fistula syndrome." The history is often pathognomic. A man is shaving himself, and, drawing back his ear, to stretch the skin of his cheek for the stroke of the razor, he compresses by accident the outer orifice of the external auditory meatus. This may cause a sudden rise of pressure in the labyrinth, and sudden vertigo, which disappears as rapidly as it came. It is an accidental and fairly exact reproduction of Ewald's experiment on the semi-circular canal of the pigeon. It indicates a live labyrinth, and, in the presence of middle-ear suppuration, suggests an erosion of the bone over some part of the tympanic surface of the labyrinth.

The causative mastoiditis must be cured by mastoidectomy. Generally a radical or modified radical mastoidectomy will be required, as cholesteatoma will usually be found eroding the bone and exposing the membranous wall. The "fistula" must not be curetted or probed, and the labyrinth is of course not opened. With the healing of the mastoid wound, the opening of the bony "fistula" will also heal, and the patient will lose his vertigo.

(*b*) *Serous labyrinthitis.* Although the pathology of this group is uncertain, it covers a number of vertiginous lesions of the inner ear, caused by infection. The popular concept is that, in the face of a perilabyrinthine infection, the hydro-dynamics of the labyrinthine fluids are upset. There may be, it is only a theory, an increase of endo-lymphatic pressure, which is sufficient to bring on temporary vertigo and loss of hearing, but it is not enough to destroy permanently the labyrinthine functions. Consequently, the patient suffers from attacks of vertigo, which may be due, either to reduction or to increase of action of the affected ear. In other words, the vertigo may be directed towards or away from the healthy ear.

The danger is that bacterial invasion may reach the labyrinth after a surgical operation designed to clear up the causative mastoid infection. The wisest course is to give a course of chemo-therapy with Sulpha-mezathine, and to perform mastoidectomy when the labyrinth shows signs that its functions are returning to normal. Considerable judgment is required in the treatment, as a mistake may cost the patient his hearing in the affected ear, and even his life from meningitis.

(*c*) *Purulent labyrinthitis* is the result of bacterial invasion of the labyrinth. The patient will experience all the symptoms of transient labyrinthine excitation, followed by those of unilateral labyrinthine destruction. In the course of two or three weeks, he will recover his equilibrium, lose his nystagmus and then appears to the casual examiner to have no labyrinthine lesion at all. This latter state of compensation is termed *latent diffuse labyrinthitis. Occult labyrinthitis* is a name which conveys better the sense that the labyrinth is dead, but the symptoms are hidden.

There is great danger in treating such a disease as this. It may be that a patient consults a surgeon for the relief of a chronic otorrhœa. If that surgeon is slack in his examination, he may easily fail to note that, beneath the infected middle ear, lies a dead and infected labyrinth. He performs a mastoidectomy or removes a polyp. The slight surgical trauma entailed is sufficient to break down those delicate fibrinous barriers which have sealed the subarachnoid space away from the bacteria in the labyrinth. A suppurative meningitis follows and the patient dies. Therefore, remember, no operation should be performed upon a mastoid which is the seat of a chronic infection, without first making sure that the labyrinth is alive. If the labyrinth is dead, radical mastoidectomy is supplemented by labyrinthotomy.

In the *manifest stage*, when the labyrinth has been recently invaded, and the signs of uncompensated activity of the other labyrinth are marked, should we operate on the labyrinth or not? A premature operation may spread the infection along the naturally performed paths from the labyrinth to the meninges, and give the patient meningitis. If we rely on chemo-therapy to control the infection temporarily, we shall be giving the labyrinth a chance to shut off these paths to the meninges by the deposition of a fibrinous barrier, and so render labyrinthotomy at a later date a safer

proposition. Have we any guarantee that the labyrinth will shut off the infection in this way ? Have we any fears that, even while we wait, bacteria have not already invaded the meninges ? Those of you who are conversant with the niceties of abdominal surgery will see in this problem a resemblance to that which confronts the surgeon, when he is confronted with a five day old appendicitis.

Probably the safest course to follow is to treat the patient with systematic penicillin and to watch carefully for any sign of meningitis. If meningitis develops during this preliminary treatment, or if he shows symptoms ominous of an evil outcome, such as increasing headache, persistent vomiting or pyrexia, the labyrinth is opened and drained forthwith. If this condition improves, the infection may be left to shut itself off in the labyrinth and, then, again under cover of systemic penicillin, labyrinthotomy is performed.

(*d*) *Other forms of infective meningitis.* In cerebro-spinal meningitis, meningococci may invade the internal ear from the meninges by way of the internal auditory meatus. Now that the death rate from this disease has been so markedly lowered by the use of the sulphonamides, increasing numbers of these unfortunate patients are to be seen. Only too often, the infection is bilaterial and the patient is left stone deaf.

Rarely following mumps, a nerve deafness may result.

Syphilis, both congenital and acquired, causes lesions of the vestibular apparatus, with loss of vestibular function.

Neoplastic.

Tumours of the eighth nerve may grow within the internal auditory meatus, and cause a progressive destruction of all the functions of the inner ear. Tinnitus, gradual loss of hearing and vertigo are the earliest and most prominent symptoms.

Should the tumour originate more medially, in the cerebello-pontine angle, the symptoms are less clear cut. Signs of pressure on the pons, cerebellum and medulla are present, together with a varying degree of labyrinthine dysfunction.

Lastly, any tumour, which causes a rise in the intracranial pressure, may cause choking of the labyrinth, in much the same way as the optic discs are choked. The latter show papillœdema, the former diminution, in varying degree, of labyrinthine function. These symptoms are more commonly produced by sub-tentorial lesions.

Menière's Syndrome.

Whatever the pathology of this syndrome may be, it is essential to remember that it is *not* associated with otorrhœa and not caused by otitic suppuration. Vertigo, together with otitis, spells pyogenic labyrinthitis of one form or another ; and a sharp distinction must be made between these two diseases.

Hallpike has demonstrated that the pathology is dilatation of the endolymphatic system due to a rise in pressure of the contained fluid.

The endolymph is derived from the stria vascularis in the scala media of the cochlea, and it is eventually lost to the endolymphatic system by diffusing through the walls of the saccus endolymphaticus. When the endolymph pressure is raised, some relief of pressure is obtained by dilatation of the saccus and, to a slight extent, by the leakage of perilymph through the aqueductus cochleæ into the sub-arachnoid space.

Symptoms. The patient complains of intermittent attacks of vertigo, of tinnitus and of gradual loss of hearing in the affected ear. In a way, the disease bears a resemblance to tic doloreux. The symptoms come on in attacks, they vary very much in intensity, and there are often intermissions of long periods when the patient is completely free from all symptoms. Further, both diseases are associated with a considerable amount of invalidism.

Etiology and Treatment.

(*a*) The pressure of a plug of wax on the tympanic membrane may bring about vertigo and deafness. The first step in treatment is to make sure that the meatus is quite free from wax.

(*b*) In infection of the upper respiratory tract, blockage of the Eustachian tube commonly occurs. This may lead to absorption of air from the middle ear and retraction of the tympanic membrane. The stapes may be pushed on by the retracted membrane and a rise in intra-labyrinthine pressure occurs. The Eustachian tubes must be inflated, as a therapeutic test, in the investigation of every patient suffering from an unexplained vertigo.

(*c*) Dederding teaches that water retention by the labyrinth is responsible for the raised intra-labyrinthine pressure. The treatment adopted is drastically to reduce the water intake.

(*d*) Retention of sodium ions in the labyrinth is also held responsible. By osmosis these retained sodium ions increase the volume of fluid in the endolymph. The treatment adopted is :—

1. Excessive drinking is forbidden, but the fluids are not drastically restricted.

2. Sodium salts in any form are kept out of the diet. No salt or bicarbonate of soda must be used in cooking, no table salt is allowed. Foods, which are rich in sodium, such as carrots, condensed milk, olives, spinach, cheese and fish or meat pickled in brine, are forbidden. Medicines containing sodium salts are stopped.

3. Ammonium chloride, 3 grammes (six ½ gramme doses each in a capsule) is given at each of the three main meals of the day. The treatment is maintained for six weeks. A two-day rest from treatment in the middle of each week is generally allowed. If ammonium chloride "does not agree" with the patient, Potassium Nitrate in the same doses may be substituted.

(*e*) *Vascular Abnormalities.*

1. Vascular spasm of the vessels of the stria vascularis may occur, in young people who suffer from the Raynaud complex of symptoms or in older people with organic disease of the arterial walls. The treatment adopted for this group of patients is by the use of vaso-dilator drugs :—

(*a*) Glyceryl Trinitrate gr. 1/150 t.d.s.

(*b*) Nicotinic Acid 45 mgm. and Thiamine Hydrochlor, 5 mgm. in young people.

(*c*) Nicotinic Acid 25 mgm. and Thiamine Hydrochlor, 25 mgm. in the elderly.

2. Excessive capillary permeability, as in allergy, is probably a cause in other patients. Treatment is by non-specific desensitisation by the injection of histamine. In severe cases, 2.75 mg. of histamine diphospate in 250 cc. of normal saline are injected intravenously. The injection must be slow, taking at least an hour and a half. The treatment is repeated daily for three to six days, and is supplemented by subcutaneous injections of a 1 in 10,000 solution of histamine base, starting with 0.2 cc. and rising by 0.05 cc. to a maximum of 1.0 cc.

(*f*) Focal sepsis is held by Wright to play an important part in the etiology of the syndrome, and he stresses the value of eradicating any such foci as can be found.

Surgical treatment of Menière's syndrome is reserved for intractable cases.

Portman's operation. On the assumption that dilatation of the saccus endolymphaticus is the result of increased endolymphatic pressure, incision of the saccus or rupture of the ductus should relieve the pressure and so cure the vertigo. In this operation, the dura mater is stripped off the back of the petrous bone until the saccus and ductus come into view, when they are incised. This operation is reputed to have no deleterious effect upon the hearing, and should be the method of choice, where violent vertigo is associated with relatively good hearing in the affected ear.

Destructive operations. These are designed to take from the labyrinth such wavering function as it may still possess, and so to hasten what is the natural end of the disease, death of the affected labyrinth and cure of the vertigo.

(*a*) Injection of alcohol into the labyrinth :—

1. Through a surgically created hole in the external canal (Mollison).

2. Through the foot plate of the stapes by needle puncture theough the intact tympanic membrane via the external auditory meatus (Wright).

(*b*) Various methods of opening the labyrinth surgically and so ablating its function have been described. Space is here lacking to allow of a fuller description.

(*c*) The vestibular nerve can be cut in its intra-cranial course after craniotomy.

All these destructive operations will of course leave the patient stone deaf on the operated side.

Vertigo does not kill. Dean Swift suffered from it for the greater part of his life and died of natural causes at the age of seventy-eight. Vertigo is a cause of inconvenience, of anxiety and of invalidism, but it does not kill. Surgical operations, designed for the relief of vertigo, may kill the patient. Any operation which opens an uninfected labyrinth opens also a path from the wound to the meninges. However low may be the mortality rate of the operation, the possible risk must be made clear both to the patient and to his relatives.

The Importance of Psychological Factors in Organic Disease

By M. P. COPLANS.

(The Treasurer's Prize Essay read by the author before the Physical Society on October 24th, 1946.)

NOWHERE is the folly and danger of semi-scientific classification so apparent as in the sub-division of human disease processes into "organic" and "functional." The distinction is a purely artificial one, the sole purpose of which would seem to be to cloak our present ignorance regarding certain clinical syndromes in a convenient but meaningless term. "Functional" has now become the refuge for the bad practitioner when he has exhausted his stock of legitimate diagnoses; he associates the term with psychological medicine as a whole, about which he is generally unreasoningly sceptical, and because he has not considered the fundamental nature of disease, he is neither interested nor able to understand the relationship between psychological factors and disease proper as he knows it.

As a broad generalisation—and conscious that such a generalisation is dangerous because there are always the exceptions—disease may be said to be fundamentally due to distorted metabolism of the organism as a whole, or of tissues or groups of cells in that organism, as a response to an external stimulus. Parasitic invasion invokes this response. Distorted cell or tissue growth comprising neoplasia is accompanied by such a distorted metabolism, although the external stimulus has not yet been appreciated. The response of the tissues to trauma or abnormal mechanical stimuli is a response of distorted metabolism; and so on. Now, the ability of the organism to remain healthy is dependent upon its ability to adapt itself to its external environment and to maintain its internal environment within the bounds of physiological compatability. If, for instance, bacterial invasion constitutes an external stimulus of such gravity that the internal environment is thrown out of equilibrium, then disease results. And there is surely good reason to suppose that external stimuli of a "perceptive" nature (one might call these stimuli "psychological factors") are equally capable of invoking a reactive metabolic dysfunction of such gravity as to constitute disease. If this conception of disease be accepted, then pure psychological disease might be described as disease in which the external stimuli are all of a perceptive nature, and the reaction is one of altered cortical cell metabolism, the symptomatology of the disease being expressed in an altered personality pattern of the individual. Organic disease would differ in so much as external stimuli of a perceptive nature would not dominate the picture, the reactive metabolic distortion would not be confined to the higher centres, and, moreover, there would in most cases be not only clinical but pathological evidence of that distorted metabolism. This evidence might consist either of the detection of abnormal metabolic products, or of the presence of demonstrable structural alteration in tissues. Now these two types of disease do not fundamentally differ, and it is conceivable that, under certain circumstances, the causative factors of the former might find expression in the demonstrable lesions of the latter.

The example *par excellence* of a disease in which a demonstrable focal organic lesion is thought to be accompanied by ætiological factors of a psychological nature is peptic ulcer. The mucosa of a stomach, which is probably hypertonic and hypersecreting, ulcerates, and this sequence of events bears a more than fortuitous relationship to a "worrying type" of individual. These are the observed facts. The immediate cause of the ulceration is not known; suffice it to say that the stomach that is prone to ulcerate is in some way or another an abnormal stomach, and clinical observation has associated such an abnormal stomach with an individual subjected to abnormal perceptive stimuli. Whether the primary abnormality be hypertonus of the gastric musculature, or hyperactivity of the oxyntic cells, or a combination of factors, some of which may not yet have been appreciated, that primary abnormality is in part, at any rate, a reaction of the tissue to an abnormal psychological stimulus. The stimulus is appreciated by the cerebral cortex, and the reaction, it would seem, is brought about by a disturbance in autonomic neuro-effector system balance; in this case, it is the reaction of what used to be called the "vagotonic" type of individual.

Because the reaction leads ultimately to a clear cut focal lesion the condition is amenable to specific medical and surgical treatment, and psychotherapy tends to be neglected. However, in muco-membranous colitis in which a hypertonic colon is secreting too much mucus, there is no clear-cut focal lesion and thus psychotherapy forms the most satisfactory basis of treatment. Whilst not suggesting that in the former case psychotherapy should ever displace the more specific forms of treatment it should nevertheless play a more important role than it does in the management of the early stages of the disease.

If the organ which is primarily affected in a disease is one which is concerned with the functional activity of the body as a whole, then the symptomatology of the disease will be general rather than focal. The hyper-functioning thyroid of Grave's Disease is such an organ and, moreover, the thyroid is an organ whose range of physiological activity is so wide, that the description of a purely quantitative derangement as being pathological must of necessity be arbitrary. The histological picture of the thyroid in Grave's Disease is one of gross over-activity, and the condition is observed to occur in subjects of "nervous disposition," and frequently to develop rapidly following severe psychological trauma. How similar is this response of the organism to the response which comprises the clinical syndrone of "anxiety state." Here again, because (in the latter disease) there is no clear-cut organic lesion psychotherapy forms the main basis of treatment; whilst in Grave's Disease it tends to be neglected in favour of specific medical or surgical procedures. Cameron, however, quotes an eminent endocrinologist who has treated all but two per cent. of a large series of cases of Grave's Disease by medical methods in which psychotherapy played an all-important role; and such treatment was rewarded with considerable success. Thus, simply because we have at our disposal specific methods of treatment for a certain disease we should not neglect the possibilities of psychotherapy if the ætiology of that disease is known to be in part psychological.

So far, the conditions discussed have been diseases in which psychological factors are thought to play a clear causative part. Considering, for example, Essential Hypertension, it is by no means certain as to whether psychological factors produce as a response an increase in generalised vasoconstrictor tone, which in turn leads tc hypertension and demonstrable damage to the arterial wall, or whether this damage and hypertension are produced by some unknown ætiological factor, the psychological manifestations following as a result of the hypertension. Probably the former is true, since in the early stages of the disease, before any arterial damage is demonstrable, simple psychotherapy may bring about complete cure. Even so, the latter is probably also true in part. As the disease progresses, the symptoms constitute fresh psychological stimuli and a vicious circle is established. Indeed, any disease, even though it be completely free from psychological causative factors may by its very presence give rise to psychological symptoms, which may in turn predispose toward some entirely different organic disease. For example, a man may suffer an incapacitating injury which may occasion him financial worry of such magnitude as to produce in him a peptic ulcer. Thus, the treatment of any disease should be influenced by the realisation that psychological factors may play a part in its causation, and also by taking into consideration the psychological changes that the disease itself may promote. This treatment, then, can never be solely scientific; always there is the personal element; always the patient's mind and outlook are to a certain extent influenced by his state of health, and in turn come to influence that state; always, then, it is the duty of the doctor to mould his patient's outlook in such a way that he is able to employ it as a therapeutic aid.

Having realised that psychological factors can influence the development and course of an organic disease, it now remains to determine to what advantage such realisation may be put. Perhaps, in time, the monumental work of Pavlov will be taken a step further and the relationship between "perceptive stimuli" and bodily reaction will be understood fully and scientifically. Until then, there is however much that can and should be done to help the "psychologically ill" person, even though it be done in part empirically. Now, the most satisfactory form of medical treatment is prophylaxis; because of the magnitude and diversity of the psychological stimuli to which the average man is subjected, it is impossible to eliminate all the undesirable ones. Obviously any sociological advance, provided it does not lead to indolence, is a step forward toward that elimination. Such sociological advance need not necessarily be related to finance. The middle-aged woman who becomes "colon conscious" does so through lack of education, not lack of money. Therefore, I would suggest that steps should be taken to rectify the appalling state of ignorance of the lay person

as regards his body. This is in part the responsibility of the educational authorities, but it is also the responsibility of the doctor; not the consultant, but the much-maligned, much laughed at, apparently obsolescent "family doctor," who may perhaps have lacked knowledge, but who had the kind of wisdom which no text-book can teach. The man who, because of his kindness and patience, established a genuine "doctor-patient relationship" and hence practised—perhaps unknowingly—the best form of psychotherapy. It is the duty of the modern general practitioner to see that no amount of scientific advance, no amount of over-work, no amount of form-filling can ever destroy that atmosphere of mutual trust and confidence which should exist between patient and doctor; which atmosphere is the very basis of successful medical practice.

Correspondence

Women Students

SIR,—It was with great concern that I read your recent remarks in Passim *re* the coming Women Medical Students. After many years spent in the service of Guy's I can but say that I am sorry to see the erstwhile camaraderie that has always existed between the men and women of this great institution in danger of being lost.

As one of the "chosen few" I can assure you that the first "interlopers," as you so rashly call them, will come knowing only too well that they are not popular, and for those who have not had the privilege of knowing Guy's as it really is, I hope and trust that the male members will endeavour, if only on the surface, to extend them a welcome and so prevent the feeling of aggressiveness that will be the inevitable result of antipathy; only thus will the future harmonious working of the two sexes be ensured.

If we have chosen Guy's for our training, it is surely to be commended in that it proves we realise that here only will we gain the right knowledge and guidance to make us successful in our chosen profession.

I am, etc.,

"A FUTURE INTRUDER."

Guy's Hospital, S.E.1.

General Practice.

SIR,—I hope Drs. Popplewell and David Ellis are right in their rather hopeful forecast for the General Practitioner, but I can't see how "General Practice will give greater scope for initiative in the future era."

It seems that those of us who are lucky enough to have Hospital work will be at least as tied down as the Specialists.

Is it not probable that we shall all be told exactly what we may, and particularly may not do, like the Army M.O.'s?

A "battle-school" casualty was rushed into a local Cottage Hospital recently. The Batallion M.O. was asked to come and help, but he could only look on as he told us he was not allowed to do any suturing—such cases had to go about 50 miles. Furthermore, he could not give the anæsthetic because he was not a "graded anæsthetist," although he had given about 1,500 anæsthetics in Practice!

Again, to quote Dr. Ellis, "the recent settlement secured by the Panel Practitioners should reassure anyone."

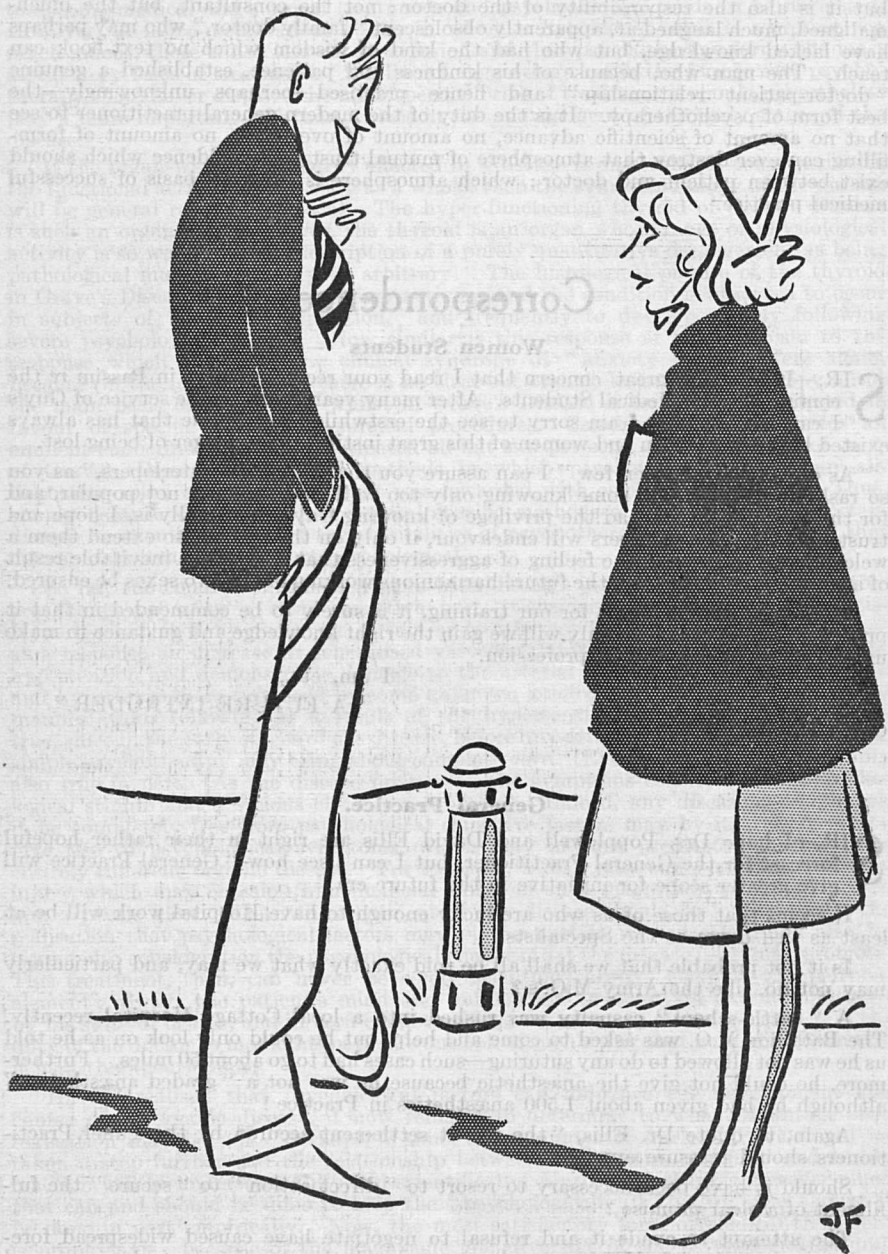
Should it have been necessary to resort to "direct action" to "secure" the fulfilment of a clear promise?

The attempt to evade it and refusal to negotiate have caused widespread foreboding even among those who were hoping to work the new Service in harmony and peace.

I am, etc.,

G. W. DRYLAND.

Kington,
Herefordshire.



STUDENT TYPES

IV. AMOROUS

Passim

SIR,—As "one of the few" referred to in your remarks in Passim of 26.10.46, I should be grateful for a little space in which to add my own observations.

Having spent 4¾ years in one of the services and, having held both "general duties" and "specialist" appointments, I elected on demobilisation to become a "G.P." This decision, I may add, caused many of my Guy's and service colleagues to shake their heads sadly and murmur, "No future in it, old boy!"

I chose general practice because I felt that it offered a life full of variety and interest, not merely as a diagnostician but also as a friend and adviser to my patients both in sickness and in health.

I also chose general practice because I believe that in any medical service, however organised, the "G.P." must be the connecting link between the patient and the specialist and is therefore indispensable.

No specialist, however gifted and however conscientious, can ever hope to show successful results unless he receives his cases in the *early* stages of disease. In my opinion the "G.P." gains as much satisfaction from an early and accurate diagnosis as does the specialist who effects a cure. Furthermore, many a brilliant result achieved in hospital can be negatived at home unless the family doctor is there to advise on after care.

I have already learnt that the immense gratitude of one's patients for even the most trivial of services cannot be valued in terms of mere money.

Those who complain that long hours and trying restrictions prevent the full enjoyment of one's leisure should remember that in "group practice" off duty can be, and is, in fact taken.

The firm of four to which I belong all enjoy a regular half day per week, three free Sundays in four, and a long week-end of three days at not infrequent intervals.

It may be, Mr. Editor, that a misguided element may feel that the posession of hgher qualifications is a certain method of assuring an easy and regulated life—short hours, a large car and "all the glamour of the West-End." From a personal knowledge of several honoraries at Guy's and other hospitals I can assure these ignorant people that the Honoraries have only attained their present status by hard work, long and exhausting days, frequent night calls and the assumption of great responsibility, often for very meagre renumeration in their early years. Having attained Honorary status they still have to work equally hard to maintain their position though superficially this may not appear to be the case.

If the possession of mere diplomas and higher qualifications is to be the sole mode of entry to the Honorary ranks of large hospitals, then it will indeed be a sorry day for Guy's and for medicine.

In conclusion, may I add that the risk of capital outlay (borrowed or otherwise) is not great in a reliable practise and "specialising" too has its financial problems, which are infinitely more hazardous, unless one is willing to sit back and wait for "1948" only to find that specialists are "two a penny" and will be remunerated accordingly by a none too generous Treasury.

"CUMULUS."

Watford, Herts.

Sport

Rugby

GUY'S *v.* PLYMOUTH ALBION.

(*Played at Honor Oak Park, Saturday, October 26th*, 1946.)

Result: Guy's 13; Plymouth Albion 11.

Guy's thoroughly deserved their victory over Plymouth Albion by 2 goals and a penalty goal to 1 goal and 2 tries in a game full of excitement. The performance of the Hospital was all the more creditable when it is mentioned that J. Keeling, the hooker, left the field through injury before half-time and F. Le Clus after a brilliant half-hour pulled a leg muscle but played on and S. F. Knipe was also off for a while near the end.

The forwards were magnificent, and never better than when they had only six men in the pack. Their tackling, pushing and covering up was better than at any time this season. Within 10 minutes of the start Owen rounded the full-back for a try which Lewis converted, following a grand movement by Strathie, F. Le Clus and F. Van der Westhuizen, but Plymouth reduced our lead with an unconverted try. Following the interval Guy's defence was subjected to heavy pressure and P. Pearne crossed for a try which A. Mundy converted and went

further ahead with an unconverted try by R. White. Guy's supporters then took a hand in the proceedings and shouted the team to a great win following a try by R. A. Dean from a line-out. T. L. T. Lewis converted in addition to kicking a penalty goal. There was much to admire in the magnificent team spirit of Guy's who moved fast and tackled relentlessly.

GUY'S *v.* OLD BLUES.

(*Played at Honor Oak Park, Saturday, November 2nd,* 1946.)

Result: Guy's 13; Old Blues 3.

A hard and interesting game against Old Blues resulted in a win for the Hospital by a dropped goal, a penalty goal, and two tries to a penalty goal. H. Brunow, a stand-off half from Cape Town, played his first game for the Hospital at left centre in place of the injured F. Le Clus. T. L. T. Lewis was in excellent form and in addition to playing a magnificent game dropped a goal, kicked a penalty goal and scored a try, but failed to convert a try by H. Brunow. The Old Blues penalty goal was kicked by G. H. Ross Goobey.

GUY'S *v.* NEATH.

(*Played at H.O.P., Monday, November 4th.*)

Result: Guy's 3; Neath 28.

To be beaten by Neath by 5 goals and a try to a penalty goal may look bad for Guy's rugger, but this Neath side is a good one and the manner in which our players stood up to a terrific gruelling brought great credit to them. It must be remembered that in the Neath side were four Welsh trials players and others not far removed. Against this massive force Guy's made many mistakes from which the opposition were quick to take advantage. On this showing Guy's will give away many points by failing to prevent the opposing forwards breaking through because thay cannot afford the risk of leaving our three-quarters unprotected. In attack there is little wrong with the forwards but they obviously lack a leader and the sooner one is found the better it will be for team work. Neath led at half-time with tries by D. P. Jones and T. James, both of which were converted by V. Evans against a penalty goal by T. L. T. Lewis. In the second half our three-quarters completely failed to hold the fast-moving Neath backs and the opposing forwards were in full cry towards the end. Further tries were scored for Neath by J. Tandy, D. P. Jones and T. Janes (2), three of which were converted by T. James.

GUY'S *v.* BIRKENHEAD PARK.

(*Played at H.O.P., Saturday, November 9th.*)

Result: Guy's 10; Birkenhead Park 26.

It must be most disheartening to the large number of Guy's supporters now flocking to the Clubs' Union ground to see our team playing so well and yet losing by big margins. It is always a pleasure to welcome old friends and we found several in the Birkenhead side that beat the Hospital by 4 goals, a penalty goal and a try to a dropped goal and two tries, after a grand game full of thrills and skilful play.

Once again it must be recorded that Guy's contributed to their own downfall by foolish mistakes when attacking and the experienced and workmanlike Merseyside players were presented with opportunities from which they took full advantage. Had Guy's held their passes and handled the ball more accurately the score would have been closer, and once again it was proved conclusively that the poor positioning which left gaps in our defence was due to lack of leadership in the pack and practically no understanding between the backs. T. L. T. Lewis tried valiantly to inspire the three-quarters but even he was caught out of position when a pass was dropped at the crucial moment and a score should have resulted. F. Van der Westhuizen nearly gave away a try when slipping in his own twenty-five within a few mimutes of the start and then R. G. Crerar crossed for the Park. M. Hatton equalised when winning the dash for the touch-down following a run and a kick ahead by D. N. H. Owen. A penalty goal by R. E. Bibby who also converted a try by K. M. Baker gave the Park a good lead. Guy's however were playing well, particularly D. M. Strathie who constantly found gaps in the Park defence and following heavy pressure T. L. T. Lewis dropped a goal from just inside the Birkenhead half. Further tries were scored for Birkenhead Park by R. N. Baker and S. Huntriss (2) all of which were converted by R. E. Bibby and in the closing stages T. L. T. Lewis took a pass from K. R. Heber and flung himself over the line.

In view of his early season form the absence of F. Le Clus through injury is a severe loss and the return of J. Keeling to the side is anxiously awaited. At the moment there need be no despondency as the team is a good one individually, and one can visualise that when all the errors are eliminated and the players can show a better understanding in their team work, points against us will be reduced, but not until the tackling of the backs is improved.

Hospital Information, etc.

Notices

DEBATING SOCIETY.

That there was a definite stirring among the ashes of the Debating Society was evident when, on 24th October, Mr. T. J. Evans took the chair for Mr. C. J. Earl, to propose "that research on atomic energy should be abandoned." In opposition was Mr. T. J. K. Boenheim. Though the attendance was small a vigorous discussion ensued before the motion was finally carried by seven votes to five, with a number of people abstaining.

Then, with the meeting held on 12th November, came a much more powerful spreading of the wings of this phœnix-like body. The constitution having been amended in the meantime to admit all those working within the precincts of the Hospital, well over a hundred people gathered in the New Theatre when Mr. G. M. P. FitzGibbon moved "that equality of professional opportunity for women is undesirable." Once again, Mr. T. J. Evans, the President of the Society, was in the Chair, while in the body of the house was a formidable representation of nurses, almoners, radiographers and others, obviously intending to lend their support to a Student-Nurse, Miss A. V. Surtees who, in spirited manner, led the opposition. As only to be expected in such company an animated exchange of views took place when the motion was thrown open to debate. In the end, despite a forceful yet persuasive speech by the proposer in his concluding address, the motion was declared lost when the

voting revealed only eighteen for, with ninety-two against.

The intention is to hold further meetings at approximately fortnightly intervals throughout the session, the next one being fixed for Tuesday, 26th November. Before *this report goes to press notices* will have appeared in the colonnade giving further details, including subject and principal speakers. Although actual membership of the Society is confined to subscribers to the Clubs' Union, nevertheless anyone who is attached to the Hospital is free to come along and take part in the discussions. Specific invitations are to be issued on suitable occasions to the students of other hospitals and colleges. The Committee hopes that by choosing topical themes they will find plenty of people who will take part in the activities of the Society.

T. J. K. BOENHEIM.
R. GOULDING.
Joint Honorary Secretaries.

DEPARTMENT OF SURGERY.

The next demonstration of standard surgical procedures will take place on Tuesday, December 3rd, at 12 o'clock, and Registrars and House Surgeons are invited. This demonstration will probably deal with the surgical treatment of varicose veins and *hæmorrhoids.*

H. J. B. ATKINS.
Director of the Surgical Dept.

ADDISON LECTURE IN ENDOCRINOLOGY.

Through the generosity of an old Guy's *man, Dr. Harry Spon, a sum of money has* been given to the Medical School for some purpose in connection with Endocrinology. It has therefore been decided to establish an Addison Lecture. This is to be given by an endocrinologist of distinction roughly about once a year. The objects are: (1) to pay tribute to the outstanding pioneer contributions of Thomas Addison to the field of Endocrinology; (2) to associate the name of Guy's at the present time with activity in this field; (3) to stimulate the interest of the Guy's student in the subject by giving him the opportunity of seeing and hearing eminent personalities in endocrinology; and (4) to pay a compliment to certain distinguished endocrinologists by inviting them to give the lecture.

The first Addison Lecture will be given in the Physiology Theatre, Guy's Hospital Medical School, on Monday, December 2nd, 1946, by Professor E. C. Dodds, M.V.O., D.Sc., Ph.D., M.D., F.R.C.P., F.I.C., F.R.S.(Edin.), F.R.S., on "Stories of Endocrine Research."

Admission by Ticket, obtainable from the Dean, Guy's Hospital Medical School.

P. M. F. BISHOP.

CHURCHES' COUNCIL OF HEALING.

A series of meetings are being held in London under the auspices of the Churches' Council of Healing, and the next meeting to be held in Denison Hall, Vauxhall Bridge Road, is on December 11th at 7 p.m.

The Churches' Council of Healing received its initial inspiration from the late Archbishop William Temple. Its primary function is to afford a recognised basis for the co-operation of doctors and clergy in the study and performance of their respective functions in the work of healing.

The Bishop of Croydon is chairman of the Churches' Council of Healing, and Dr. Burnett Rae (Physician for Psychological Medicine, Croydon General Hospital) is chairman of the Medical Committee of the Council.

VICTOR T. McCLAUGHRY,
Chaplain's Room,
Guy's Hospital.

PHYSICAL SOCIETY PROGRAMME.

Programme for the Physical Society for the remaining portion of the Christmas Term is as follows:—

Thursday, November 21st.—Dr. W. B. D. Maile, M.D. "Experiences in Malarial Control in S.E.A.C." at 7.45 p.m.

Thursday, December 5th.—Combined Clinical Meeting with St. Thomas's at 7.30 p.m. in the Pre-Clinical Class Room.

The opening meeting of the following term will be on Thursday, January 16th, 1947, when Sir Herbert Eason, C.B., C.M.G., F.R.C.S., President of the G.M.C., will address the Society on "What a doctor must not do."

The time and place of meeting will be announced later.

Meetings will be held every second Thursday until April 24th, 1947. Subjects of papers will be announced later. The Clinical Meetings will take place on January 30th, February 27th, March 27th and April 24th, 1946.

PATRICK CLARKSON.
S. H. LLEWELLYN SMITH.

FRIPP MEMORIAL FELLOWSHIP.

The Sir Alfred Fripp Memorial Fellowship in Child Psychology at Guy's Hospital, open to medical graduates, men or women (unmarried) preferably with experience in Pædiatrics as well as in Psychological Medicine. Stipend £250 a year. This appointment is for two years and may be held concurrently with a part-time appointment elsewhere. Applications should be made to the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, *on or before Friday,* December 6th, 1946.

ASSISTANT LECTURER IN PHARMACOLOGY.

Applications are invited for the post of Assistant Lecturer in Pharmacology. Com*mencing salary £575 per annum with super*annuation. Applications should be sent to the Dean, Guy's Hospital Medical School, London Bridge, S.E.1.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

August, 1946.

Surgery.—*W. F. Belsham.

Pathology, Bacteriology and Forensic Medicine.—*R. N. H. Vann.

October, 1946.

Midwifery.—J. O. Kelsey.

ROYAL COLLEGE OF PHYSICIANS.

October, 1946.

M.R.C.P.

J. P. Crawford J. Luder

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.

October, 1946.

Pass.

J. J. Ashken
G. F. Barnes
L. W. Bowen
G. L. Burgess
J. Candy
D. W. J. Cullingford
M. J. Cutler
D. G. L. Davies
J. F. de la Fresnaye
R. W. Hughes
M. Kugler
O. G. Lane
I. A. H. Munro
B. H. Pickard
D. D. Rees
P. A. J. Smith
R. J. Stanley
G. F. Swann
R. G. Watson
T. T. Woodall
C. J. Zerny

Supplementary Pass List.

PART I.

S. Adler, B.Sc.
G. C. Ambrose
J. H. Apted
J. H. Baylis
R. H. Browning
M. P. Coplans
W. M. Dixon
J. B. Eades
R. L. Edwards
D. H. Forsdick
J. G. Hamilton
S. J. Harris
J. L. Hayward
A. J. Heber
K. E. Hodge
R. H. Hughes
A. J. I. Kelynack
C. D. Korn
B. Kustow
J. E. Mandel
B. C. Morgan
T. E. Oppé
H. H. B. Perkins
T. W. Renton
E. Robinson
K. J. Robinson
P. R. McH. Scales
D. J. Sheerboom
J. G. Stebbing
J. A. Sutton
P. J. F. Walsh
R. D. Willcock
P. Wilson

PART II.

S. Balfour-Lynn
H. Goldschmidt
D. G. A. Westbury
I. Yentis

PART III.

R. L. H. Barnard
P. S. Clarke
D. O. Davies
G. W. Downes
P. J. Dwyer
J. M. Holmes
J. D. Oriel
J. A. Stewart
J. A. Turner
G. F. Vaughan

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

F.R.C.S.

PRIMARY EXAMINATION.

November, 1946.

J. F. R. Bentley
G. D. Channell
H. A. Ripman
L. F. W. Salmon

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

FINAL EXAMINATION.

November, 1946.

PART I.—Surgery.

R. A. Dean
R. E. Feaver
B. Frankel
E. J. Williams

PART II.—Dental Surgery.

L. D. Carton-Kelly
R. K. Foster
B. Frankel
G. R. M. Mote
G. E. Rybaczewski

UNIVERSITY OF CAMBRIDGE.

M.D.

The degree of Doctor of Medicine was conferred on W. B. D. Maile on October 19th, 1946, and on M. A. Rushton on November 2nd, 1946.

Change of Address

J. L. Harrington, L.D.S., R.C.S., 27, Weymouth St., London, W.1. (Tel.: Langham 3913.)

J. C. Matthews, M.R.C.S., L.R.C.P., s.s. "Empire Cutlass," c/o Houlder Bros. & Co., The Avenue, High St., Hull.

J. D. L. Reinhold, B.M., B.Ch., 31a, Ravensbourne Road, Bromley, Kent.

P. Maxwell Stephens, L.D.S., R.C.S., Royal Victoria Infirmary, Newcastle-on-Tyne 1.

D. P. Wheatley, M.B., B.Ch., Croxley Villa, Croxley Green, Herts.

A' M. G. Campbell, B.M., B.Ch., M.R.C.P., Physician to the Bristol Royal and City Hospitals, 62, Pembroke Road, Clifton, Bristol, 8.

D. G. Dixon, M.R.C.S., L.R.C.P., Wortley House, Haxby, Yorks.

W. L. Trick, L.D.S., R.C.S., 30, Market Place, Boston, Lincs. (Tel.: Boston 2816.)

Papers by Guy's Men

Carpenter, E. B. Nutrition and the fall of Empires. *Med. Pr.*, 1946, **216**, 269.

Burn, J. H., and Another. Theories of anæsthetic action. *Brit. Med. J.*, 1946, ii, 533.

Batchelor, J. S. The treatment of uncorrected club foot in children. *Proc. Roy. Soc. Med.*, 1945-6, **39**, 713.

Cohen, S. M. Arterial advances of orthopædic concern. *Ibid.*, 718.

Harvey, Warren. Some recent research into dental amalgams at the R.A.F. Institute of Aviation Medicine, Farnborough, Hants. *Brit. Dent. J.*, 1946, **81**, 245.

Bradley, W. H., and Others. Influenza-B in 1945–6. *Lancet*, 1946, ii, 627.

Wright, G. Payling and Clark, W.M. Anergy in infants' skin to diphtheria toxin. *Clin. Sc.*, 1946, **6**, 13.

Layton, T. B. Sore throats and tonsillitis. *Pract*, 1946, **157**, 349.

Barber, Hugh. Winter ailments of the old. *Ibid.*, 357.

Bankart, A. S. Blundell. Low back-pain and sciatica. *Ibid.*, 367.

Marston, A. D. Anæsthetics in obstetric practice. *Ibid.*, 372.

Blacker, C. P. Social problem families in the lime-light. *Eugenics Rev.*, 1946, **38**, 117.

Houghton, L. E., and Others. Spreading suppurative pneumonitis. *Thorax*, 1946, **1**, 146.

Clegg, J. W., and Others. Effect of asbestos and of asbestos and aluminium on the lungs of rabbits. *Ibid.*, 188.

Ogilvie, Sir Heneage. The Nursing of shock and hæmorrhage. *Nursing Mirror*, 1946, **84**, 97.

Appointment

Martin A. Rushton, M.A., M.B., B.Ch., L.D.S., has been appointed Nuffield Professor of Dental Medicine at Guy's Hospital Medical School.

Births

EVANS.—On November 10th, 1946, at Nuffield House, to Winifred (née Groom), wife of M. L. Hudson Evans.—a son (Timothy).

GOULDER.—On November 1st, 1946, at Guy's Hospital, to Margaret (née Oliver), wife of R. V. H. Goulder.—a son (Nicholas).

Deaths

PEARCE.—On November 12th, 1946, Sir Frank James Pearce, L.D.S., R.C.S.(Eng.), D.D.S., Penn., of 108, Frognal, Hampstead, N.W.3, and 57a, Wimpole Street, W.1.

EDS. { R.T.H. D.H.F.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

WE take the greatest pleasure in announcing yet one more appointment to the Honorary Staff. Mr. F. R. Kilpatrick has been appointed Assistant Surgeon to the Genito-Urinary Department. No more happy choice for the Hospital could have been made and, together with the large number of the younger Guy's men who, as ward-clerks and dressers, have had Mr. Kilpatrick as their registrar, we express to him our congratulations and unmatched delight at the news of his honour.

The tide of current affairs makes critical the time for all our national institutions. And as for them so for our hospital and its school. Long years of war had deprived it of material facilities and, albeit the less readily, done something to shrink its spirit. The hunger of the armed forces had taken away so many of the staff that those who remained to bear the brunt of teaching and practice had grown weary with their service. But when the battle ceased Guy's began to regain her breath. She is still doing it.

This then being the crisis we await its resolution. The fame and tradition of two centuries is the seed which, properly nutured, can flower into a great future. But untended it will surely die and those responsible will hear a just reproach for their lack of stewardship.

As the final success of an army in the field or a navy on the seas lies in the quality of leaders and led, so with a medical school. However gilded the buildings and equipment of the future they will avail nothing if teachers and taught are unworthy of them.

Doubtless, these things are in the minds of those called upon to select the successors of them whose work is done and thankfully remembered. Yet having chosen the best when the best are most needed there is a danger that for a space they may be lost. Within the last two or three weeks a newly-appointed member of the Honorary Staff has been hustled away for service in the army and this after scarcely more than a month's work. Let us say at once that the eligibility of those who saw fit not to serve in the forces during the war does not concern us here, save to observe in passing that unless such a man is essential for his work of the moment there is no justice in his now escaping the duty he, or others, thought right he should delay. What does concern us is whether the place of a member of the staff of a hospital whose fortunes are in the balance is here in the place for which he was specially selected or in an army doing police duties elsewhere in an unsettled world.

Quite apart from the more parochial interest of this hospital there can be no underestimate of the importance of educating a new generation of doctors. That, from the national standpoint, is paramount and not to be gainsaid. Why then deliberately misuse the means to the end ? It is never easy to determine responsibility for ill-conceived and unimaginative actions and less so in the matter we are discussing.

The first step in calling up an unwilling man is presumably taken by the Central Medical War Committee acting as it were as press-gang for the never-satisfied service chiefs. If his moral fibre is still unstretched, the individual concerned will certainly do as he is bidden without recourse to favour or plea. Thus it remains for the school

authorities, who alone are able to assess his value to them, to intervene on his behalf. We have said already that the filling of an appointment is an acknowledgement of the chosen man's usefulness and value and it might be thought that being so acclaimed he would not readily be cast aside.

It is therefore hoped that in the case of the member of the staff already lost to us, that our authorities did their utmost, if unsuccessfully, to prevent the harm which must be done in a teaching school by such an unfortunately ill-timed act. Moreover, if further calls upon the staff are expected in similar circumstances we may wish for a strengthening of the opposition lest it become considered unprofitable to appoint any man who has not yet done his military service.

It is well to turn to consider the effects on teaching brought about by these deprivations of staff. They will depend upon what measures are undertaken to fill the gaps in the interim. There appear to be three alternatives. The first, which is impossible, is to fill the vacancies with men of standing equal to that of the temporarily departed; thus would be embodied the wisdom of maturity with the still bright spark of youthful originality and as yet unprejudiced vigour. The second would be to place the whole burden of precept and example upon the registrars who are themselves *in statu pupillari*. Such a solution is unthinkable and would be as undesirable for them as for the luckless dressers and clerks of the firm. The third possibility is the one most likely to be adopted by inviting a retiring member of the staff to hold the pass until the return of his successor.

This step is surely unsatisfactory for two reasons. So great is the loyalty of the Guy's staff that a request of this nature could be scarcely refused and a man who has served the hospital faithfully the greater part of his life becomes denied the retirement he so well merits. Again, senescence is a curious phenomenon. For the many it means only an inability of the body to do the feats of yesterday or obey readily the will of to-day; the brain still is agile and pregnant with the wisdom of the years. But in the few, the once glittering mind of ripe judgment and constant inspiration loses its light and sheds its lustre. These whims of Dame Nature make absurd the appointment of age-limits for retirement be they sixty, sixty-five or even eighty; for it is not the span of life but the favour of the gods which brings to a close man's fitness for his calling.

So for those still equal to the task it is asking much that they should labour on against the day of their successors' return from the Forces; and for those who in their service have spent themselves, that they should suffer the cruelty of youth's profanity in having their last word. Mathew Arnold gave the warning:

> "Charge once more, then, and be dumb!
> Let the victors, when they come,
> When the forts of folly fall,
> Find thy body by the wall."

The reports in the daily press have sounded an alarm for our profession and the sister-profession of nursing. Whatever may be the advantages of what has come to be called the "closed shop" in other walks of life, it had occurred to few of us that we ourselves might have to reckon with this new order of things. That nurses should be given notice of dismissal when the hospitals of England are short of between twenty and thirty thousand would require adequate justification at any time. But that the reason for this step is their not belonging to a trade union or its satisfactory alternative seems nonsense and does little to reassure those who are doubtful for the future fortunes of the medical and nursing professions when their affairs fall into the hands of the State. The Willesden Borough Council has been reported to have issued the orders as part of the execution of its policy and that in itself is small recommendation for the conduct of a learned profession being influenced by the butcher, baker and candle-stick maker. In addition, it makes sad reading that the notices in question were signed by Dr. G. F. Buchan. Although not a Guy's man, he holds the appointment in the Medical School of Lecturer in Public Health. He is, of course, the servant of the authority to which he is Medical Officer of Health, but that does not indulge

him the privilege of forgetting that he is a doctor, too. Neither is it forgotten that the threat of dismissal has been extended to two brother members of his own profession. Dr. Buchan is entitled to his own opinions but it is unfortunate that he has become involved in such a serious matter of high principle.

We publish on another page a letter from Dr. Stafford-Clark.

In it he reproves us for want of responsibility and circumspection towards the branch of medicine in which he practises. More, we are in his debt for what amounts to a gratuitous consultation through the post. Our psychopathology has been revealed and our difficulties and complexes from which we are accused of flying to the heights of aggression pointed out. For all this we are grateful but at the risk of being uncooperative in our therapy would point out to Dr. Stafford-Clark that he misses the point. It is not for the mentally ill that we exercise our guffaws but for their would be healers who zealous in their mercy, a characteristic of priestcraft in every age, so often increase the burden of their patients' affliction. R. R. Marett recounts how when learning to ride a bicycle he had the misfortune to run over a cur. "I hope your dog is none the worse," he gasped to the owner. "Well, he ain't none the better," was the Oxfordshire rustic's reply. There are occasions when it might be better for psychiatrists to take upon themselves the wisdom of the neurologists, standing back from the bedside to have said to them:

"The doctors as they took their fees
Said, 'There's no cure for this disease.'"

Ridicule is seldom unearned by practitioners of new ideas. Witch-doctors, recognised now by anthropologists, like the Early Church have borne their share but the passage of time and the immortality of their doctrine eventually have silenced the cynics. One day a more sober psychiatry taking itself less seriously and blessed with a sense of humour will do the same.

In our issue of 9th November a letter from Mr. B. J. Rickard asserted that the *Gazette* is the official organ of the Medical School and Hospital. For the enlightenment of those contemplating libel actions we hasten to make it known that this is not so.

With great regret we bid farewell to Mr. St. John Rumsey, M.A., Instructor of Patients with Defective Speech. He has been on the Staff of the Hospital since nineteen twenty-three and is very well known in his field of work. On behalf of our readers we wish him a long and happy retirement but cannot let him go without a word of thanks for his interest in the heraldry of Guy's. A further important article on this subject appears in this issue.

Two other faithful servants of the Hospital are also retiring. Mr. W. J. Sell, Foreman Electrician, leaves us after forty-eight years' service and Mr. R. Butler, Coal Trimmer, after forty-six years. In assuring them of our good wishes we would like them to know that their work and their loyalty will be remembered thankfully.

We extend our good wishes to Mr. Michael Price, the oncoming President of the Residents who succeeds Mr. J. K. Martin as holder of this ancient and honourable office.

We have obtained two delightful drawings of the Hospital by Mr. Hanslip Fletcher, one of which "Guy's House from the Park" appears on another page. Copies may be obtained from the *Gazette* office, price three shillings and sixpence each. Postage is sixpence extra.

Obituary

SIR FRANK PEARCE, L.D.S.(Eng.), D.D.S.(Penn.).

SIR FRANK PEARCE was a righteous man and held a place in the hearts and affections of a great many. He entered Guy's Hospital as a student in 1897, and worked hard at many things right up to within a few months of his death. As a student he was very assiduous and soon came to the fore. At this period, too, he was a keen sportsman and played regularly in the 2nd Rugby fifteen for two years. At the end of his student career at Guy's and having qualified at the Royal College of Surgeons, he was awarded the first travelling scholarship of the Dental School, journeyed to the United States, and soon obtained the degree of Doctor of Dental Surgery at Pennsylvania. After this he returned to London and was appointed to the Teaching Staff of the Dental School in 1901, resigning in 1931 owing to slight failing health. Sir Frank was a very able teacher and many will remember the help he gave to all those who were fortunate enough to come under his tuition. He was also a great source of strength on all School Committees, having the courage of his convictions.

In addition to his work in his private practice and here at Guy's, he took a very active part in the work of the British Dental Association, which he joined in 1903, and was soon made Chairman of the then General Purposes Committee and later became its Honorary Secretary from 1912 to 1918, and Vice-Chairman of its Representative Board for 1924–5. He was then elected President of the Association in 1936. This year of office as President was an important one, for at its Annual Meeting of that year the British Dental Association welcomed representative dental surgeons from all parts of the British Empire. It was after fulfilling this office and for his valuable work for the Association and the profession that His Majesty honoured him with a Knighthood.

From 1939 to 1946 Sir Frank was a member of the Central Dental War Committee, which body dealt with the disposal of the personnel of the Dental Profession, often a difficult and arduous task.

Last but not least of Sir Frank's many activities, there is one outstanding in which he acted as Chairman for many years and only resigned a few weeks ago, on account of ill-health—namely, the Benevolent Fund of the British Dental Association. Very few know anything with regard to the inner working of this Fund, for the benefits it administers and dispenses are mostly confidential, but Sir Frank put his whole heart into his work as Chairman, and had a very close grip on all the details of its benefactions, and "all for love and nothing for reward."

"To live in hearts we leave behind is not to die."

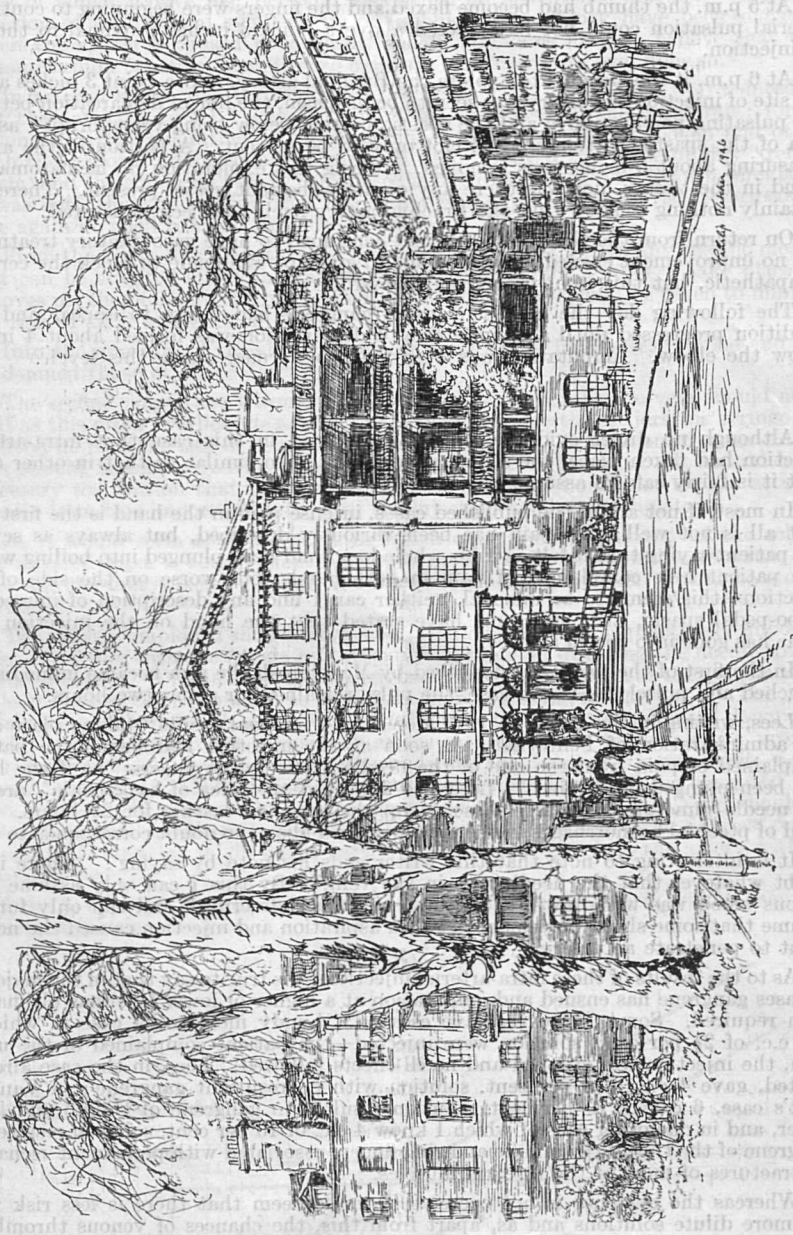
E. B. D.

A Case of Intra-Arterial Injection of Pentothal Sodium

BRIAN D. JOHNSON, M.R.C.S., D.A.

E. N. was admitted to hospital for a gluteal abscess; it was decided to open this under Pentothal Sodium anæsthesia. At 12.50 a.m. the anæsthetist entered the needle of the syringe into what appeared to be the median-cephalic vein of the left arm, and after aspirating venous looking blood, began to inject slowly a 10 per cent. solution of Pentothal. After 2 c.c.–3 c.c. had been injected the patient began to move his mouth, but taking this to mean that he was tasting "sulphur," the anæsthetist continued to inject a further 4 c.c. of the solution. The patient was by now anæsthetised and the abscess was incised. It was then noticed that there had developed a band of ptechial hæmorrhages just above the cubital fossa about 3 inches broad.

60–90 seconds later the patient groaned and then complained of pain in both arms, especially the left: the left hand and forearm became livid and both feet and hands went into a typical carpo-pedal spasm: both radial pulses were equal and of good volume.



GUY'S HOUSE FROM THE PARK

By 3 p.m. the left arm had become white and flaccid and no pulse was detectable at the wrist. During the intervening period the arm had been placed under an electric cradle, and alcohol by mouth, Papavarine and Carbachol had been given.

At 5 p.m. the thumb had become flexed and the fingers were beginning to contract: arterial pulsation could not be detected above a point 3 inches proximal to the site of injection.

At 6 p.m. it was decided to explore the Brachial artery. At a point 3 inches above the site of injection the artery was seen to be in spasm, the line of demarcation between the pulsating portion above and the spastic portion below being very abrupt: aspiration of the spastic portion showed clot only to be present. A portion of the artery measuring about 5 inches was removed. During this exploration no hæmatoma was found in the tissues, nor was there any obvious aberrant vessel present. There was certainly nothing to show that the Brachial artery itself had been punctured.

On return from the theatre the patient continued to have vaso-dilatory treatment, but no improvement ensued, so at 11 p.m. an attempt was made to block the cervical sympathetic, but this, too, proved unsuccessful.

The following day the earliest signs of gangrene had begun to appear and this condition progressed until a definite line of demarcation was formed about 4 inches below the elbow. Amputation was eventually performed above this level.

DISCUSSION.

Although no direct evidence could be obtained in this case that intra-arterial injection had taken place, the sequence of events is so similar to that in other cases that it is fairly safe to assume it.

In most, if not all, of the published cases, intense pain in the hand is the first sign that all is not well; this pain has been variously described, but always as severe, one patient saying that it felt as if his whole hand had been plunged into boiling water. The patient here complained of pain in both hands, but worse on the side of the injection—this seems to be unusual, neither can I find any description of immediate carpo-pedal spasm, although some have stated that the hand on the injection side alone has gone into spasm at once.

In the first of the two cases described by Mackintosh the arm became immediately blanched and pulseless—in our case, the pulse remained for about two hours.

Lees, writing in the *Lancet* in 1943, described "unusual events" taking place after the administration of Pentothal. As soon as the injection had begun the patient complained of pain from the site of the needle down to the fingers "as if the hand had been plunged into a fire"; Lees also described an "area of hyperæmia" around the needle puncture spreading 4 inches up the arm and lasting for 24 hours. The band of ptechial hæmorrhages in the case described above no doubt corresponds to this.

It is interesting to note that this writer ends his note by saying: "There is no doubt whatever that the needle was in the vein." By this I can only assume that venous blood was withdrawn, as in the case I have described, and can only further assume that some slight movement between aspiration and injection caused the needle point to penetrate an artery.

As to the results of these intra-arterial injections it is true to say that in the majority of cases gangrene has ensued and amputation at a higher or lower level has ultimately been required. Some, however, have escaped. Lundy mentions a case in which a few c.c. of 2½ per cent. solution were injected—the patient complained of the usual pain, the injection was stopped and no ill-effects followed. Lees, in the case already quoted, gave 4 c.c. of 5 per cent. solution with no resultant gangrene; in Van der Post's case, 6 c.c. of 10 per cent. solution resulted in gangrene of thumb and little finger, and in one other case of which I know 4 c.c. of 10 per cent. solution resulted in gangrene of the tips of the middle and ring fingers associated with permanent ischæmic contractures of most of the forearm muscles.

Whereas the evidence is not coercive it would seem that there is less risk with the more dilute solutions and as, apart from this, the chances of venous thrombosis and periphlebitis are greater with a 10 per cent. solution, I feel that the use of this strength can no longer be justified.

Now as to treatment, many suggestions have been made. On the grounds that it might paralyse the local sympathetic fibres, the injection around the artery of Procaine

has been advocated ; I have no experience of this, and am not in a position to discuss it. The other steps which might be taken to produce vaso-dilatation, such as alcohol, carbachol, the application of heat, etc., do not seem to be successful. In the two cases of which I have had personal experience no benefit has accrued. Again, the injection of the cervical sympathetic or brachial plexus block have been suggested, but if the spasm is caused by a local " reflex " it seems hard to believe that these measures could benefit : I can find no evidence that they have ever done so.

In arterial spasm due to other causes—*e.g.* trauma, it has been well pointed out that the damaged vessel " reflexly " maintains the spasm of the collaterals ; for this reason an early exploration of the artery has been advocated by Cohen and others. With the removal of the damaged part has been removed the cause of this " reflex " spasm, and the collateral vessels can consequently dilate to re-establish the circulation. It was with this end in view that the artery was exposed in the case described, but here again no good resulted from the excision.

From the above it is evident, then, that there is not yet known any specific measure that can be adopted should an injection of Pentothal into an artery take place. It behoves us, therefore, all the more to consider, what steps should be taken to minimise the risk of such an injection.

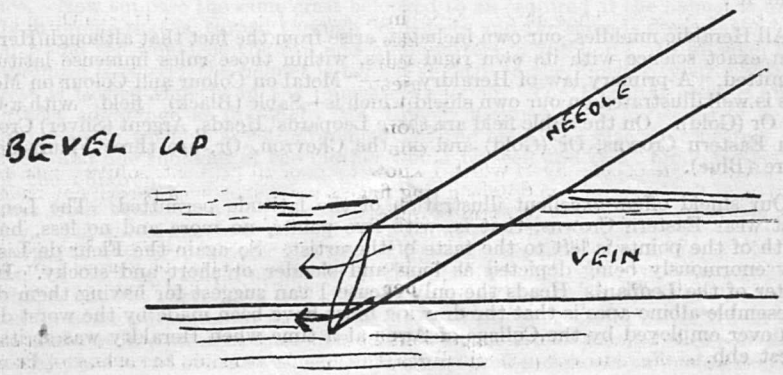
Into the question of the strengths of the solution we have already gone and have condemned those of above 5 per cent.

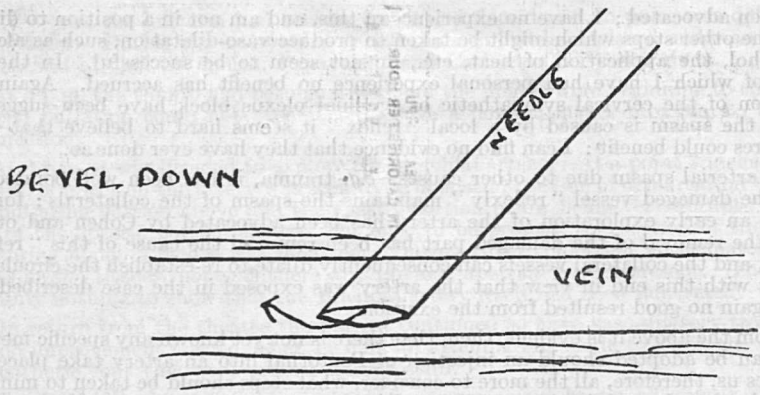
The second point that I would make is that the median-basilic vein should not be used as this often overlies the artery, and should the anæsthetist jerk his syringe even slightly, he runs the risk of penetrating the latter vessel. Palpation over the selected vein should become a routine habit before the injection is begun. It should be unnecessary to mention that the nurse steadying the arm should not let her attention wander from this important duty until the injection has been completed.

As it would seem that the cases in which only a small quantity of the solution was injected have a better chance of recovery it would be advisable to pause after injecting the first ½ c.c.–1 c.c. ; in the event of pain the injection should be stopped forthwith.

The syringe employed should have an eccentric nozzle as it is practically impossible when using one with the nozzle centrally placed to avoid directing the needle towards the deep tissues. Once the needle has entered the vein the barrel of the syringe should be held applied to the forearm so that both move, if at all, as one piece. The needle should have a short bevel, and I would advise that this be always pointed downwards. With the bevel upwards it is easier to arrive at a situation in which the proximal part of the lumen of the needle is in the vein while the distal part is outside it—*i.e.* has passed through it. Under these circumstances, venous blood will be aspirated while fluid injected will pass partly into the vein and partly outside it. Now, should the distal part of the needle be in the immediate vicinity of an artery the slightest onward thrust while injecting might cause part of the lumen to give into the artery with dire consequences.

If the bevel is pointing downwards the dangers are minimised as will be seen from the accompanying diagram.





Unless there are real reasons to contra-indicate it—*e.g.* thrombosis, encasement in plaster, etc.—the injection should normally be given into the left arm in right-handed persons. This may seem a pessimistic doctrine, but when one remembers how many people earn their daily bread by their right hand, and the enormity of the misfortune of losing this from an intra-arterial injection, every precaution should be taken. To justify the injection of a drug which might, however small the chances, result in amputation, into the right arm for no definite reason, might be difficult indeed in the teeth of counsel for the prosecution in a case of damages.

REFERENCES.

Van der Post. Anæsthetics and Analgesics, 1942, 3, 58.
Lundy. Clinical Anæsthetics, 1942, p. 542.
Mackintosh & Heyworth. *Lancet*, Nov. 6, 1943.
Lees. *Lancet*, June 19, 1943.
Cohen. *B. Med. Bull.*, 1944, Vol. 2, No. 7.

The Heraldry at Guy's Hospital

By H. St. JOHN RUMSEY, M.A.

THE interesting and informative article written by Mr. Kenneth Hooper in July and the two letters questioning the right to a peer's helmet and the correctness of the leopards' heads, call for answers and a summing up of the whole matter. Being a case where angels fear to tread it was suggested that I should do something about it !

All Heraldic muddles, our own included, arise from the fact that although Heraldry is an exact science with its own rigid rules, within those rules immense latitude is permitted. A primary law of Heraldry is :—" Metal on Colour and Colour on Metal." This is well illustrated on our own shield which is—Sable (Black) " field " with a Chevron, Or (Gold). On the Sable field are three Leopards' Heads, Argent (Silver) Crowned with Eastern Crowns, Or (Gold) and on the Chevron, Or, are three Fleurs de Lis, Azure (Blue).

Our shield offers excellent illustration of the latitude permitted. The Leopards must wear Eastern Crowns, that is, with five points, no more and no less, but the length of the points is left to the taste of the artist. So again the Fleur de Lis may vary enormously being depicted as long and slender or short and stocky. In the matter of the Leopards' Heads the only excuse I can suggest for having them drawn to resemble albino apes is that the drawing must have been made by the worst draftsman ever employed by the College of Arms at a time when Heraldry was at its very lowest ebb.

In his article Mr. Hooper rightly condemns the use of a helmet without a crest displayed on it. This is a real blunder obvious to any student of Heraldry; the primary object of a helmet is to carry the crest, its secondary object is to denote the rank of the wearer of the arms. The helmet displayed by us fails in both ways, but more of this presently.

It is worth noting that in the earlier grants of arms there were no crests; these were introduced much later. No one can have a proven right to a crest unless he has a right to a coat of arms, but the converse is possible. In all these matters the College of Arms is the arbiter; they hold all the records; no records—no proven arms! In Mr. Hooper's drawing he showed a peer's helmet; that is a mistake but a very natural one because in the original drawings issued from the College of Arms the helmet resembles that of a peer rather than that of an esquire. I think it was intended to be an Austrian pageant helmet so the mistake was a natural one, and I admit that I was equally misled, but knowing, as I did, that we could have no right to a peer's helmet, the only course open to me was to refer the question to the College of Arms. One official said that an esquire's helmet was intended but that it was easily the worst drawing of such a helmet ever sent out by them. A second official blamed the German influence at that time, but both agreed that a more accurate drawing was urgently wanted. That is the verdict and there is no appeal. If and when a new drawing of the complete heraldic achievement is wanted, that is with supporters, shield, motto, helmet with mantling and crest, the helmet, to be correct, must be drawn in profile with the visor closed. For the information of any who may be interested, the heraldic helmets are as follows:—The helmet of the sovereign and the royal princes is of gold in an affronté position (full face) and must have grilles (bars). Helmets of peers are silver drawn in profile with golden grilles, usually five in number, but this is not essential. Helmets of knights and baronets are shown full face with the visors open while those of esquires are steel in profile with closed visors.

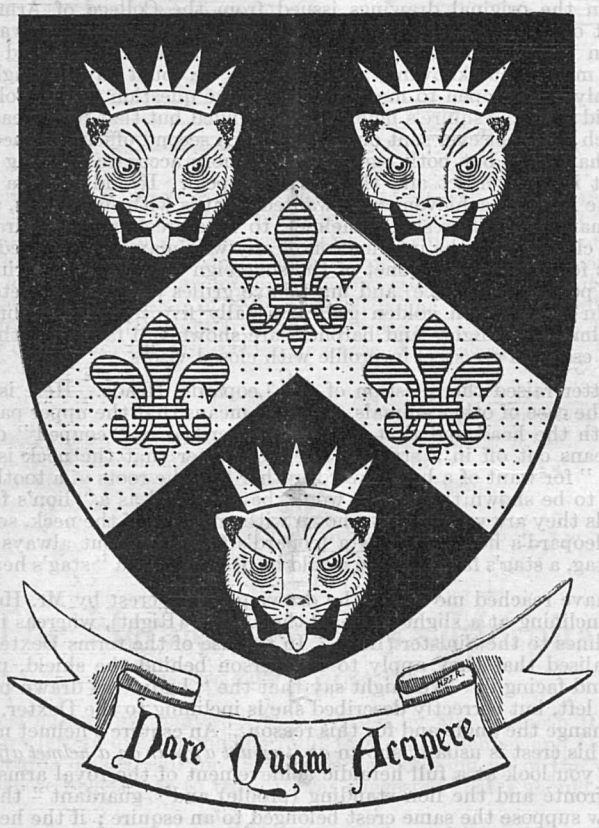
Another letter raised the question of the Leopards' Heads. Here is the Heralds' verdict:—In the case of other animals, "head" means that the upper part of the neck is included with the head and that it will be described as "couped" or "erased"; the former means cut off in a straight line, the latter that the neck is divided into three "prongs" for want of a better word, rather like the roots of a tooth. If no part of the neck is to be shown the charge would be described as a "lion's face." In the case of leopards they are very seldom shown with any part of the neck, so a "leopard's face" or a "leopard's head" means a leopard's face only, but always affronté. In the case of a stag, a stag's face affronté would be described as a "stag's head caboshed."

Murmurs have reached me about the drawing of our crest by Mr. Hooper because he showed it inclining at a slight angle to the Dexter (Right), whereas in the original drawing it inclines to the Sinister (Left). In the use of the terms Dexter and Sinister it must be realised that they apply to the person behind the shield, not to anyone looking at it and facing it. We might say that the "Lady" as drawn by Mr. Hooper inclines to the left, but correctly described she is inclining to the Dexter. Mr. Hooper was right to change the angle and for this reason. An esquire's helmet must be drawn in profile, but his crest is usually shown *as it would appear on a helmet affronté.* As an illustration, if you look at a full heraldic achievement of the royal arms, you will see the helmet affronté and the lion standing (profile) and "guardant" that is showing full face. Now suppose the same crest belonged to an esquire; if the helmet is drawn exactly in profile that is, turned through 90 degrees and the same is done to the crest, all you would see would be the tail and hindquarters of the lion! In all such cases a compromise is usual; the helmet is turned slightly to the Sinister (your right) and the crest is turned slightly in the opposite direction. The Hospital crest is shown to the best advantage as drawn by Mr. Hooper because if on an esquire's helmet exactly in profile without any compromise and the crest was placed accurately only the profile and one shoulder of the mother would be seen and the "hindquarters" of one of the children.

Apart from accuracy which is essential, readers may ask what constitutes good heraldry. The shield should be as plain as possible so as not to distract attention from the charges and their positions and the charges should be drawn as large as space permits. A "spade" shield as shown in the first drawing is usually considered the ideal shape, but the curved top and sides shown in the second drawing is more easily adapted for some purposes, for instance to wear on the pocket of a blazer which itself has a pocket cut in a straight line. The curved shield avoids parallel lines; no doubt this is why the curved shield is almost universally used in schools and colleges.

A word is needed about the shading. In Heraldry the colours are almost, if not quite, as important as the charges on the shield, so all heraldic achievements should be shown in full colours whenever possible; unfortunately, the cases when this is

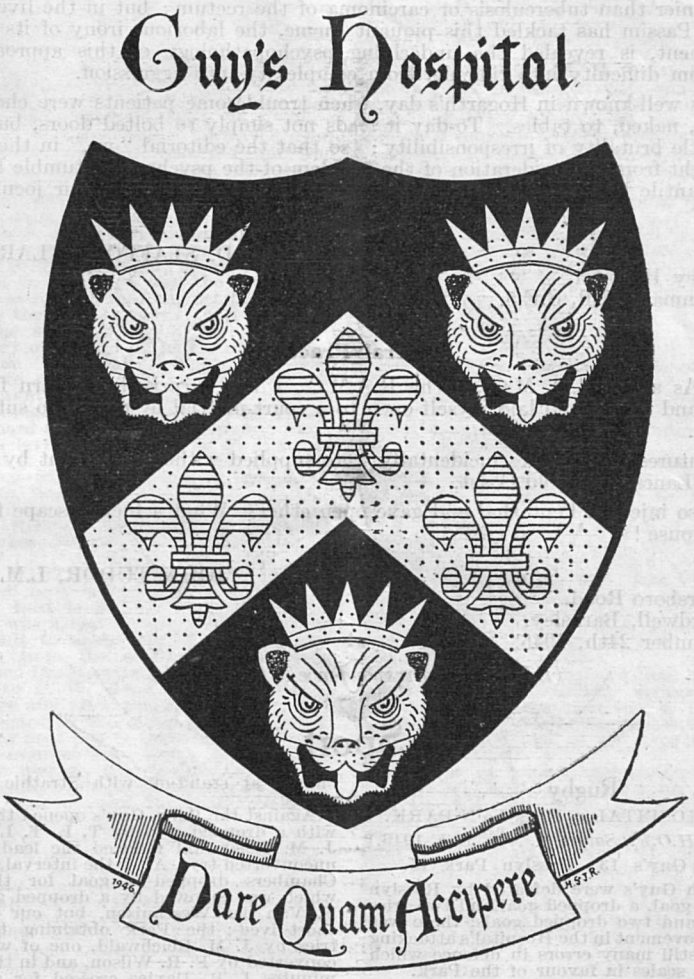
Guy's Hospital.



impossible are numerous. To take but two instances, the front of the *Gazette* and the headings on our writing paper. To meet this difficulty a scheme of shading exists as follows:—Horizontal lines denote Azure (Blue), perpendicular lines—Gules (Red). For Sable (Black) cross-hatching (perpendicular and horizontal) is used, but it is usually thought better to black in completely as the drawings show. Or (Gold) is indicated by dots and Argent (Silver) is shown by leaving the surface plain.

It is now very usual to omit all lines to indicate colours and metals; they may be a trouble to include, but if omitted they cause endless confusion. In our own case if the shield and chevron are shown without any clue to colour or metal, the same drawing will denote, 1, Red on Gold. 2, Blue on Gold. 3, Black on Gold. 4, Red on Silver. 5, Blue on Silver. 6, Black on Silver. 7, Gold on Red. 8, Gold on Blue. 9, Gold on Black. 10, Silver on Red. 11, Silver on Blue and, 12, Silver on Black. These are only those in most frequent use. In our own case generations of Guy's men wore the shield with a royal blue "field" instead of a sable. This mistake was corrected as recently as 1937. Display in colours if in any way possible, if impossible use the formal shading, otherwise the drawing has no heraldic meaning.

A last word about the Mantling. As students of Heraldry will know, the mantling follows the principal colours of the shield, so we might expect to see our mantling Sable and Or, instead of which it is shown on the original grant (1725) as Gules and Argent. These colours it seems are not due, as we might suppose, to the contrast between the red tongues of our leopards and the white robes that scarcely conceal the opulent charms of our supporters. The reason is simpler; up to the end of the seventeenth century all mantling was shown in Gules and Argent whatever the tints of the shield might be. At the beginning of the eighteenth century the general rule



came in that the colours of the mantling should follow those of the shield, but this rule was not rigidly enforced for a long time. We have a fine Heraldic Achievement and a magnificent history but our grant was made when Heraldic artists were at their worst, so we must hope that in the near future the Hospital will ask the College of Arms for a new drawing. If this is done we shall see our arms unchanged except for the fact that they will be pleasant to look at as well as being a possession of which we are and should be proud. Meanwhile, I hope that readers will remember that Heraldry is a complicated subject and to know all about it is a full time job; I have done my best and where I have been uncertain I have consulted the final arbiters who have been most kind and helpful in helping us out of our muddle.

Correspondence

Passim

SIR,—In the same number of *The Gazette* containing an intelligent appreciation of one aspect of Psychological Medicine, Passim, not to be outdone, weighs in with a characteristically ludicrous contribution to this subject.

In some quarters mental illness is always a safe bet for a guffaw; intrinsically much funnier than tuberculosis or carcinoma of the rectum; but in the lively spirit in which Passim has tackled this piquant theme, the laborious irony of its attitude to treatment, is revealed the underlying psychopathology of this approach; the escape from difficulty into ridicule, from complexity into aggression.

It was well-known in Hogarth's day, when troublesome patients were chained by the ankle, naked, to tables. To-day it leads not simply to bolted doors, but to the more subtle brutality of irresponsibility; so that the editorial "we," in their determined flight from a consideration of the problem of the psychopath, tumble headlong to an infantile level. Only by remaining there, can they retain their jocular complacency.

Yours faithfully,
D. STAFFORD-CLARK.

Maudsley Hospital,
Denmark Hill, S.E.5.

General Practice.

SIR,—As an ex-G.D. M.O. in the R.A.M.C., I was surprised to learn from Dr. Dryland that I had laid myself open to a court-martial by daring to suture unit cases.

The sutures and needles incidentally were supplied without comment by C.R.S's. in Essex, Lancs. and Gold Coast.

We also injected Pentothal and gave open ether. What a lucky escape from the "Glass-House!"

Yours,
JOHN TUDOR, L.M.S.S.A.

12, Worsboro Road,
Birdwell, Barnsley.
November 24th, 1946.

(*Ed.—This correspondence is now closed.*)

Sport

Rugby

GUY'S HOSPITAL *v.* ROSSLYN PARK.

(*Played at H.O.P., Saturday, Nov. 16th*, 1946.)

Result: Guy's 13; Rosslyn Park 15.

Although Guy's were defeated by Rosslyn Park by a goal, a dropped goal and two tries to a goal and two dropped goals, there was much improvement in the Hospital's attacking play, but still many errors in defence which turned the scales in favour of the Park.

The writer has usually confined himself to a commentary on the games together with snatches from the run of play, but it appears quite definite that the present back division representing the Hospital is wrongly placed. The weakness lies at centre and D. M. Strathie at stand-off half is not getting sufficient help from the scrum or his centres to bring out the best in him. Therefore, remembering Strathie's success as a centre in M. R. Mullin's team, and when he himself was captain, I would suggest that F. Van der Westhuizen or G. P. Billingham who has been playing very well for the "A" be given a chance at stand-off with Strathie at right centre.

Against the Park, Guy's opened the scoring with a dropped goal by T. L. T. Lewis, but J. M. Reichwald reduced the lead with an unconverted try. After the interval, K. G. G. Chambers dropped a goal for the Park, which was followed by a dropped goal from F. Van der Westhuizen, but our lead was short-lived; the Park obtaining two good tries by J. M. Reichwald, one of which was converted by F. R. Wilson, and in the closing minutes I. B. Davies crossed for a try for Guy's which T. L. Lewis converted.

There were several changes in the Guy's pack owing to injuries and P. Rademan playing his first game for the senior side in the back row played very well. F. Van der Westhuizen improved on previous performances which suggests that left centre is best suited to his type of play.

Guy's opportunities were strictly limited owing to the persistently good hooking of J. R. Tyler for the Park, and in addition the Park had a fine attacking left wing in J. M. Reichwald who was very difficult to pull down.

Association

GUY'S *v.* GOLDSMITH'S COLLEGE.
(*Played away on Wednesday, Oct. 23rd.*)
Result: Won 4—3.

As frequently happens against the Hospital Soccer side, our opponents opened the scoring with a snap shot from just outside the penalty area, which was completely beyond reach of our goalkeeper. This reverse after about ten minutes play was quickly remedied by our United Hospitals' inside-forward Sturdy. From a well-placed centre by the right wing, his characteristic first-time shot found the net in record time.

Then followed a misunderstanding which enabled Goldsmith's to resume their lead. A pass-back from Riches to our goalkeeper was unfortunately intercepted and the ball was next seen to be in the net.

The faces of our forwards portrayed grim determination as they returned for the kick-off and before very long this spirit was rewarded by a goal from Leckie, who, as is usual, gave the goalkeeper no chance at all to impede the flight of the ball.

After some thirty-five minutes play our opponents were awarded a most doubtful penalty. It was, however, saved by Whittaker, but so unsettled was the team that the ball was scraped into our net to give our opponents the lead.

Half-time score: 2—3.

The story of the second half is one of hard fighting on both sides. Guy's, however, appeared to gain gradual mastery over the game. Twenty minutes after the interval a push-through from Newton enabled Leckie to shoot hard and score the equaliser. With the scores level it appeared to be anyone's game, and it was not until almost the final whistle that Sturdy relieved the tension by scoring our leading goal.

Team: Whittaker; Matthews, Holloway, Newton, Riches, Swift; Skaith, Sturdy; Leckie, Sykes, Merrill.

GUY'S *v.* SOUTHAMPTON UNIVERSITY.
(*Played away on Saturday, Nov. 2nd.*)
Result: Lost 4—5.

As this was a new fixture for the Club, it was difficult to assess the strength of our opponents from the scattered information that reached the Hospital. We are indebted, however, to P. W. Head for his assistance both before and after the game.

With regard to the game itself, however, the opening goal was to the benefit of Guy's. After ten minutes play Leckie found a gap and from outside the penalty area shot hard to score. Our opponents were quick to reply, however, and the score remained for some time at 1—1.

Twenty-five minutes had elapsed when Leckie again scored with an excellently-placed shot. At this stage of the game the defence was temporarily "off form," and the home team thrice scored in quick succession. Guy's, nevertheless, were not without their share of bad luck, for several times Sturdy and Lewis threatened to reduce the posts to firewood.

At half-time then the score stood at 2—4.

Soon after the resumption of play, much to the dismay of the Hospital team, Southampton increased their lead. Then Guy's really got down to business—time after time well-formed movements swept towards the visitors' goal, but the ball managed to cross the goal-mouth without being diverted into the net. The ever-ready Leckie eventually retrieved his shooting prowess and awarded the Hospital with two quick goals; so that with ten minutes to go the score stood at 4—5, and despite further repeated attacks we were unable to equalise, and a most evenly matched game resulted in our first defeat.

Our thanks are due to Southampton for the excellent post-match entertainment which was afforded us. It would have been a little more encouraging to see a greater degree of response to their splendid gesture.

Team: Whittaker· Matthews, Swift; Newton, Riches, Sykes; Lewis, Skaith, Leckie, Sturdy, Head.

It may be of interest to know that of the eleven matches played, nine have been won, and two lost. The Hospital has gained seventy-five goals with the loss of twenty-eight.

Athletic Club

Owing to the unhealthy state of the Club at the time, it would have been an ill-conceived move to say anything about it when the notices concerning the activities of other constituent clubs of the Clubs' Union appeared in a recent issue of the *Gazette*.

Even now the policy and future of the Club are unsettled, but a start was made by setting up a sub-committee to revise the existing rules, which were found to be hopelessly out-of-date. The redrafted rules have been approved by the Club, and now await approval by the Clubs' Union Council. As to the future, all depends upon the support which will, or will not, be forthcoming. Tentative arrangements have been made for next season—matches with public schools and so on—and it is earnestly hoped to revive the Sports in June.

The Athletic Club has for long had a precarious existence, mainly because of the participation of its members in the major sports and the commitments with outside clubs binding several of the more prominent Hospital athletes.

There is no lack of talent, even though some of it is dormant. This is an appeal for all those who can come forward to do so—firstly, at the Annual General Meeting in January, when the medical school returns after the Christmas recess. At this meeting officers for the coming season will be elected and other matters fully discussed.

The Athletic Club has a fine tradition to maintain, but may well be unable to maintain it without enthusiasm and co-operation in the future.

R. H. N. LONG.

Hospital Information, etc.

Notices

DEBATING SOCIETY.

For the meeting held on Tuesday, 26th November, the Debating Society could hardly have chosen a more contentious subject than "that Russia is a menace to world peace." Altogether about fifty people assembled in the Biology laboratory, the ladies being somewhat in the majority, to hear Mr. A. Scorey put this proposition to the House. After he had dwelt on the various aspects and episodes which, he contended, contributed to his view, Mr. J. Whelden, an official speaker for U.N.O., took the opposite stand. To him the Society must be greatly indebted,

not merely for giving up his time to be present at all but, more especially, for delivering a highly informative address in a most gifted manner. The speeches from the floor of the House probably betrayed more dogma than reason but at least the principal advocates were able, at the end, to present a comprehensive summary of each side of the argument. When put to the vote by the Chairman—a role taken by Mr. R. T. Hinde in exemplary style—the motion was declared carried by twenty-four to eight.

To conclude the programme for the present term arrangements are proceeding for the final debate to be held in the Anatomy theatre on Thursday, 12th December, at 4.30 p.m. Dr. R. Clitherow, M.P., an executive member of the Medical Practitioners' Union, will then move "that this House deplores the attitude of the British Medical Association towards the National Health Act." Replying on behalf of the Association will be Dr. R. W. Cockshut, a member both of the Council and Negotiating Committee. Although these two practised speakers will undoubtedly subject the new scheme to a critical appraisal, their observations are unlikely to be exhaustive nor can they be expected to range far from the standpoints of their own respective organisations. It is therefore hoped that a large number of students and others will come along and bring their particular reactions to bear on this question for it is one, upon the outcome of which taking the country as a whole, the shape of the new service that means so much to the profession will depend.

T. K. BOENHEIM,
R. GOULDING,
Joint Hon. Secretaries.

SOCIAL MEDICINE.

A course of lectures in Social Medicine will be given by Professor John A. Ryle, M.A., M.D., F.R.C.P., Professor of Social Medicine, University of Oxford, in the Physiological Theatre at 1 p.m. as follows :—

Tuesday, January 7th, 1947 : "The Meaning of Normal and the Measurement of Health."

Tuesday, January 14th, 1947 : "The Natural History of Tuberculosis."

Thursday, January 23rd, 1947 : "The Social Pathology of Rhuematic Fever."

Thursday, January 30th, 1947 : "Peptic Ulcer as a Social Problem."

DEPARTMENT OF SURGERY.

Mr. Slesinger will conduct a departmental round for senior students and post-graduates in Lydia Ward at 10 a.m. on Saturday, December 14th. Cases of disease of the Thyroid gland are being shown. Old Guy's men are especially welcome.—H. J. B. Atkins, *Director.*

UNIVERSITY OF LONDON O.T.C./S.T.C. WAR MEMORIAL.

Contributions are invited for amending the existing 1914–18 War Memorial, situated in the Senate House of the University, to include members of the University of London O.T.C./S.T.C. who gave their lives in the 1939–45 War, by :—

(*a*) the addition of dates on the actual Memorial ;

(*b*) the insertion in the casket of a Scroll of the Fallen ;

(*c*) the compiling of a book containing the names and other details to be placed beside the 1914–18 book.

Should the balance of funds be sufficient, it is also proposed to form a Trust Fund to assist in the education of children of past members who died in the 1939–45 War.

Cheques, etc., should be sent to the Hon. Secretary, University of London Military Education Committee, Imperial Institute Building, South Kensington, S.W.7, to whom they should be made payable.

GUY'S HOSPITAL STUDENTS' UNION.

At the recent Annual General Meeting of the Students' Union, Prof. T. B. Johnston, C.B.E., M.D., was elected President of the Union for the ensuing period of office. It is with great pleasure that we announce that he has accepted this office.

The following officers were also elected :—

Chairman : Leonard Jacobs.
Hon. Sec. : Jack Palmer.
Hon. Treasurer : Ian Scott.

J. PALMER,
Hon. Sec.

MUSIC CLUB.

The gramophone has now been repaired and lunch hour concerts will be resumed in the "Pathology Theatre," in the New Medical School Building, every Thursday from 1 to 2 p.m.

Boxing Club

The club is meeting Cambridge University and the Polytechnic B.C. on December 18th, in the Hospital Gymnasium.

Pass List

UNIVERSITY OF OXFORD.

Pass List.

M.D.

The degree of Doctor of Medicine has been conferred on Thomas Arthur Madden.

The Services

AWARDS.

Territorial Decoration.

Capt. George Ellis, M.A., L.D.S., has been awarded the Efficiency Medal (Territorial), Army Dental Corps.

Appointments

J. H. Mayer, M.B., F.R.C.S., Orthopædic Surgeon, County of Kent.

Weddings

BARNES—WILLIAMS—On 20th November 1946, at Buckland Monarchorum, Devon, Lieut. Robert D. I Barnes, R.N.R., to Diana Williams, Q.A.R.N.N.S./R.

Births

MAYMAN.—On November 16th, 1946, to Vivienne, wife of Denis W. Mayman, of Brow Lee, Wosborough Dale, near Barnsley —a son.

SPENCER.—On November 25th, 1946, at Sumner Court Nursing Home, Southborough, Kent, to Audrey (née Betts), wife of Surgeon-Lieutenant (D) John S. Spencer, R.N.V.R.—a daughter (Anne Denise).

STEER.—On November 22nd, 1946, at Limpsfield, Surrey, to Elizabeth (née Maxwell-Stephens), wife of Charles Steer—a son.

WHEATLEY.—On November 21st. 1946, at Watford, to Alex, wife of David Wheatley M.B.—a son (Trevor Neil Pearse).

EDS. {R.T.H. D.H.F.

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PASSIM

"*Peace on earth; good will towards men.*"

IN this season of the year the ancient exhortation bids us anew. Reminded, we hasten at its call and writing, cast aside for a space remonstration, bubble-pricking and witch-hunting seeking not to divide by the sharp thrust and angry word but rather with King Wenceslas think well of all men and with them share the tidings of Yule. If this Feast mean anything it means friends and family, for where they are it lives and in them continues through the centuries. When, therefore, we hear allusion to the Guy's family it is not for us to dismiss the notion as naught but sentimental, instead to take pleasure in its conception and pride in its truth.

Thus duty and desire being at one; and as members of this great corporate body we wish all others of the family the compliments of the season, the tidings of the year.

"The dark night wakes, the glory breaks,
And Christmas comes once more."

It is good for us to reflect that our family is as widespread as it is diverse. Healers and healed, nurses and doctors, teachers and taught, neither and either. Those who are here, those who have left; those at home, those abroad. To all of them who share the hospital as the focus of their affections, the mistress of their labours or the sweetest of their memories we say "A merry Christmas."

And what is this merry Christmas? Is it of the spirit, the mind or the belly? At its best, surely of all in their parts yet blended withal. Byron misplaced the emphasis:

"Let us have wine and women, mirth and laughter,
Sermons and soda water the day after."

Better the sermons not afterwards to reprove what has gone; but rather before to sanction these inducements to subsequent joy. Better the soda water not for the flatulence but to soften the fragrant distillate of kindly barley. Even the Philistines would not follow the sweet spice by the bitter draught and thought we like them, nor would we.

Here we speak not of the spirit but think for a moment of mind and belly. Their satisfaction is their stimulation by good company, good food and good wine. What more certain recipe for happiness than these providing, as they do, the precious acquisitions, "laughter and the love of friends?" Not even stern times succeeding sterner days can wholly make hopeless the quest for these incomparable jewels. Pity the man whose world extends not without himself for as the hungry become the starving, the scorners of wine the shedders of salt tears, so do the friendless become the cheerless. "Life is to be fortified by many friendships," wrote Sydney Smith and who should know better?

Good company without food or wine has its own intrinsic merit. To-day, it must but in that respect forfeits a little of both polish and grace. Yet if that is true the converse is as false, or should we say it is a half-truth? Lord Lytton puts it:

"We may live without poetry, music and art;
We may live without conscience and live without heart;
We may live without friends; we may live without books;
But civilised man cannot cannot live without Cooks."

and George Meredith gives Mrs Berry's advice as "kissing don't last dear; cookery do." More than one statesman's belly has influenced profoundly the course of history or the fate of nations. Was it not said of a recent Chancellor of the Exchequer that the austerity of his budgets derived from the ulceration of his stomach? Or who has not noticed that the good fellowship and bonhomie of the night before foreruns the morose intolerance of the morning after? Thus, in the last analysis it is the physician who guides the stream of world affairs, and having the key sees a new significance in the old reproach, "A man's mind is in his belly."

After food—wine. Lord Birkenhead's "bottled sunshine from the sunny south" of hoary age and mellow dignity gives place to a parentless infant from Algeria, uncomely if welcome Thackeray's advice we take:

"Welcome the wine whate'er the seal is,"

and of this child of lowly birth we are not too proud to say with W. E. Henley:

"The spirit of Wine
Sang in my glass and I listened
With love to his odorous music,
His flushed and magnificent song."

and then after the tale of his virtue and fame,

"The Spirit of wine
Sang in my heart, and I triumphed
In the savour and scent of his music,
His magnetic and heartening song."

Alas, for most of us we must rest content with the words:

"Then go we smoking,
Silent and snug;
Naught passes between us
Save a brown jug—
Sometimes!"

So, a generation may be unable to heed the old warning ascribed to a certain Master Isaac Judaeus, "It is impossible for them that drinketh overmoche water in their youth to come to the age that God ordained them." For the trouble is that we have too little of what Arthur Clough knew to be necessary when he reflected:

"One ought to be grateful, I quite apprehend,
Having dinner and supper and plenty to spend,
And so suppose now while the things go away,
By way of a grace we all stand up and say—
How pleasant it is to have money, heigho-ho!
How pleasant it is to have money."

Doubtless, this very lack prompted an Oxford don to regret over the wireless recently an absence of nonsense in university life. Heaven protect us, especially at Christmas, from those who take themselves too seriously and that is our justification for meditating upon these things of the flesh that we may the better understand the more worthwhile values they promote at this time of the year and in a selfish, drab and ugly age.

Finally, we raise our glass, without telling what is in it, to our readers, bidding them in the old words :

"Good morrow, masters all."

FORTUNE has provided us a new cartoonist. Three of Mr. Steer's works appear in this number. In congratulating him upon them, we trust that his relations with his victims will remain cordial.

WE apologise for not making it quite clear last week that only one of Mr. Hanslip Fletcher's drawings is at present available. It is "Guy's House from the Park." The second picture will be reproduced when the paper is obtainable.

WE have news that Sister Opie, formerly Assistant Matron, has been appointed Matron of King's College Hospital This is an honour indeed and with our congratulations to Miss Opie we couple our good wishes.

KEAT'S HOUSE in St. Thomas's Street is now open and provides most comfortable apartments for the conduct of private consulting practice. They are tastefully appointed and fulfil an unquestionable demand. We have no hesitation in recommending the propriety of this *salon* to anyone in Belgravia who may view with distaste a visit to the Borough.

It is interesting to note that no long years have passed since nearly all the Guy's staff had their rooms in this historic and still gracious street.

A Ghost at Guy's

Silent am I, half seen, vanishing at a touch,
Waiting and peering in the underground ;
Palely inquisitive—but not to harm,
Simply alert for old familiar sights and scenes—
An H.P. on a late night round
May catch a glimpse of me
Then I am gone. I make no sound ;
His footsteps and the crickets' cheeps echo unchallenged ;
Yet I am never far from here. . . .
I am a faithful, friendly spectre ;
As you moderns say,
I float around.

Who am I then ? It matters nothing
I might be
Some ancient extern whom Time's Scythe has claimed
Pedalling his phantom cycle through the Gusty Park. . . .
Or else a Borough child
Feasted one Christmas long ago, in Out-patients
Now haunting the loved scene of his enchantment.
I could be a Nurse,
A Student, or a Resident whose day is past—
Perhaps I was a porter, old and wise ;
All that counts now is :
I was part of Guy's.

So, after Blitz and burning, blood and tears,
As from earth's corners, drifting back, come her old sons
To join her young ones,

As the threatening years
Pass on and leave Guy's standing, I
Who saw it all, rejoice my ghostly heart,
Cry, with my soundless voice
" It was well done. . . ."
And drink a silent toast to everyone ;
(For at this season even ghosts have fun).
Wish all at Guy's a merry Christmas, too.
You won't see me ; but I'll be seeing you ! Anon.

The Christmas Spirit

—So fill your belly
And, jump on a chair ;
What's there in jelly
But, water and—air— !
What's there in jelly
Take a cup full of laughter,
Be merry to-day
—And sorrowing after.
Make merry to-day,
Let the spirits run wild !
—Man-made spirit is short
—Have a bitter or mild.

Let's shout the odds
To our small pewter Gods—
Fill 'em up for a shilling,
Drain 'em back if you're willing,
—Warm your heart
—Throw a dart
—Bang you face on a cart
Or the Thames' muddy bottom :
Take no thought of the morrow,
Headaches are when you've gott'em ;
—In the matters of money
You can frequently borrow
From an uncle or honey.

So . . . fill up your belly
And spring in the air,
What's there in jelly
—A prickly pear ?
No ! a lump of mauve gelatin
—Plenty of water !
. . . There I knew I was wrong
I must have something strong !
Say, a quarter
Of Porter—
Suits down to the ground :
—Why, this building goes round ;
Then I steady it gently
To save it from falling
And everyone's bawling,
I can't understand—
Now who's this on my hand
Oi ! I can't hear a word
—And feel quite absurd :
—Wake me up
In the morning, old man,
If you can. . . .

J. G. P. H

Quidam Notus Homo

By H. St. H. VERTUE.

A LARGE man got off an omnibus at London Bridge and walked towards Guy's. He came by omnibus and not by car because the sleek, squat, shiny, cimiciform motor car ill became his solid, dignified appearance. (The nicest sort of car is like that of my friend J., a picturesque ruin held together in places by strips of elastoplast, but still, in the beautiful language of the day, mobile, and ever at the disposal of those who need a lift). He came by omnibus and not by tube, because as he explained, he suffered from migraine. "I have seen their notice," he said, "if you spit, you are fined two pounds; so I suppose if you vomit—," but the rest of the apodosis was lost in laughter. Very little of this personage, for such he was, was visible. He wore a large greatcoat which enveloped nearly all of him, and above this came the swathings of a white scarf. On top of him was a tall hat, worn at a somewhat jaunty angle. Between came a face of a square shape and a ruddy hue. The forehead was broad and indicated a brain-case that was the receptacle of an organ of no mean size, the lower jaw was well developed and gave an air of determination, the mouth was hidden by a moustache of gingery colour that lent him a pugnacious look, and the eyes of this formidable man were small, rather deeply set, of a cold, steely blue and their glitter was enhanced by a pair of pince-nez. With a portly gait, apparently wrapt in thought, he proceeded through the colonnade. A young gentleman attached himself but seemed scarcely to be noticed. At the board he paused and scanned the list of post-mortems, but finding nothing to interest him, passed on. Arrived at length at a ward, he hung up his hat and revealed a massive head and fair hair carefully brushed to hide the thinning on top. He got himself out of his enormous greatcoat, unwound from his neck yards and yards of white scarf, methodically hung these garments up and disclosed to the beholder, this incredible man, that he wore a frock-coat, a thing now only done by shop-walkers and himself. That nothing should be missing, a handsome gold watch-chain spanned his waistcoat.

By this time a crowd of students had gathered round (a crowd in those days was six or eight) and a Sister had greeted him; but he did not seem to be very much aware of her. He stalked towards the first bed with his following, fished out the report, grinned faintly, uttered a sound half-way between a deep sigh and a grunt, and having thus metaphorically hitched himself up, began. Gazing down at the patient he let his first words fall forth, slowly, distinctly, emphatically, "And how, as a matter of fact, *are* you?"

The patient was a costermonger, obese and flabby, who complained of breathlessness and præcordial pain, and the physician suspected that there was alcoholic degeneration of the heart. He asked him how many pints of beer a day he drank. "Four or five," replied the man. "What!" came the incisive question; "do you never drink more than that?" "Oh, only when I back a winner." At this unexpected response the firm laughed and a dramatic transformation overcame the questioner. The cold fire was quenched in the eyes, the lids puckered up, kindly creases appeared at the corners, the stern jaw relaxed, the mouth dilated and there pealed out a hearty laugh, the most infectious I ever heard. Here was a man not simple. Useless to try to affix to him a label; stern or jovial, kind or cold. One could not even precisely say whether he was polite or not; for although he scarcely took any notice of any one, almost disregarded the Sister and called the nurse "the damsel," he never failed in any point of manners.

Having settled the affair of the man with the bad heart, he went on to the next bed. He saw there a boy suffering from tuberculous disease of the spine, stretched out on an iron frame, with his legs wide apart. This contrivance had been fashioned by a practitioner in orthopædic surgery, then a new study. We were not used to such machines as this and they seemed to us horrible, reminiscent of the torture-chambers of the Middle Ages. Moreover, the nursing staff was not used to them either and the youth had developed bed-sores. The physician discussed the advisability of sending him to the Treloar Home; he licked his lips; something was coming. He went on in measured tones: "But, of course, he would not receive there the *expert nursing* he is getting here." He licked his lips again. Then he turned to the woman he had chastised and asked her what she fed the patient on. "Oh, jellies and shapes," she stammered out. "And what, as a matter of fact, *is*—a shape?" Tension was relaxed, and the firm laughed once more. He never referred to the bed-sores again

except to prescribe for them: he ordered allantoin and they healed up. Allantoin is just becoming fashionable.

Having arrived at the next bed he asked for the ophthalmoscope, wishing to examine the eyes of the man, who was suffering from chronic nephritis. It was still necessary to use reflected light, so he arranged his beam, removed his glasses, leaving himself very short-sighted, sat on the bed, brandished the ophthalmoscope in the way that one used to, and prepared to inspect the fundus oculi, displaying the while to our fearful and fascinated gaze the spectacle of a wide and gaping chink left by his forgetfulness to do up every single one of his fly-buttons except the top. Myopic though he was, he saw. In a matter-of-fact way he reached out his hand, took down the "bed-letter" and laid it nicely over the offending gap. He examined the right eye, picked up his impromptu fig-leaf, crossed round to the other side of the bed, replaced it, examined the left eye and delivered a sound discourse on retinitis; then hung up the bed-letter, resumed his former station, courteously turned his back on Sister and said in his usual clear and resonant tones: "And now let us adjust our person," suiting the action to the word. Nothing ever flustered him. As a witness in court, it was said, he was absolutely imperturbable, his knowledge was so great, his logic so faultless and his self-command so perfect that no counsel ever got the better of him.

Arrived at the next bed he found a patient not long admitted, who was suffering from rheumatic fever. He read the report with not a few sarcastic remarks, examined the patient with care and licking his lips with evident relish directed the ward-clerk to listen to the heart again. The young man could add nothing to what he had written down. The physician dropped his stethoscope on the bed and gazed into nothingness with a stony glare. "Do *you* mean to tell *me*," he said at last, "that you cannot hear an aortic murmur?" "No, sir," replied the student, meaning of course yes, sir. Then the wonderful change occurred again. The sternness relaxed, the lines softened, and he regarded his pupil with kindness and amusement. "My dear boy," he said, "I can only show you these things. Of course, if you cannot hear them when they are there—"; and he left him to conclude that he was any sort of a duffer that he liked.

No doubt he expected rather too much of his student. He was the possessor of a very fine ear, most carefully cultivated, he played the violin and he would aver that he could detect a difference of a thirty-second of a semitone. It is a commonplace to point out that the physicians of that day had trained their senses better than those have done who practise now. They depended on them much more, because the aids to diagnosis furnished by the laboratories were so much less. So, as a blind man dependent on his senses of touch and hearing, develops these acutely, the older physicians made the most of all of theirs that could be used at the bedside. He was a particularly fine percussor. He taught himself by percussing the patient first, making marks on the chest with metal strips and then confirming his findings with the X-ray machine. I count it fortunate to have been trained by him in this matter. The art seems to be in danger of disappearing too. At any rate the students that came my way during the war had, as a rule, little or no idea of how to do it. Towards the close of his career his passion for percussion began to get the better of him and he would sometimes make a diagnosis of "root-phthisis" in a tired patient, which was not really justifiable: but this was a mere fleck on a splendid canvas. The extreme acuity of his hearing led him on one occasion to suppose a faint murmur was present, when in fact it was probably not, or if present was of no significance. When a certain patient was dying of an unknown fever, he declared at last that he could hear an aortic murmur and that there were vegetations on the valve. After the end had come, a forward youth, who would score off the great man, stepped forth and told him that the medical registrar had examined the valves and found no vegetations. To the delight of the by-standers he was not at all non-plussed, but instantly replied in caustic tone, "If you get a man to make the examination, who cannot see these things when they are there—," the rest, as so often happened, being drowned in laughter. But if you suppose that on account of a single such preposterous incident this very astute man often made mistakes, then in Lucretian phrase,

Avius a vera longe ratione vagaris.

For his knowledge was exact, his mind strictly logical, his observation very keen and his senses scarcely ever played him false. He habitually visited the post-mortems on his own patients and it was rare that he was wrong in any important respect. In fact the only two I can remember are that recorded above and one other, the case of an infant, in which he made a plausible and confident diagnosis of "fat sclerema." But unknown to him a subcutaneous saline had been improperly injected and become septic: the hard subcutaneous matter was tense, imprisoned pus, not congealed fat.

He was the first physician at Guy's who was a scientist. He had never been a registrar, but came straight into the wards from the department of physiology, bringing a refreshingly new outlook and new methods. The older men seemed to rely on knowledge of human nature, a prodigious memory for cases and a kind of intuition, to get their results. Their only interests were diagnosis and the pathology of the dead-house, things good in themselves, but not enough. They seemed to make little use of their reasoning faculty and they rarely cured anyone: to tell the truth they seldom tried. Treatment they seemed to consider beneath them. They never taught it and hardly ever ordered it, only very seldom breaking out to recommend seven and a half grains of potassium bromide or so many minims of the syrup of the iodide of iron. If you care to look at an old Taylor or an old Osler, you will see what I mean. "Aconite may be given," "Arsenic may be tried," the pure conjunctive implying the speaker's thought, "if you must do anything at all." To tell the truth, to leave the schools of physiology and pharmacology and to enter the wards was to experience what is called to-day "a flop," because four years of work seemed to have no bearing on what was going on therein. The outlook of some of the younger men was quite different, and what one owes to B. and to C., from Cambridge both, cannot well be told; but among the seniors the lamp of the new learning was held aloft only by the man that I am now describing. Brusquely, even violently, he swept aside traditional lore, applied to the material before him the scrutiny of his senses and argued thence by reason in the light of knowledge. It was just at this time that a new and strikingly original book appeared. It was called a text-book of pathology but it was utterly unlike the usual thing. Four of its most important contributions came from Guy's men, Ryffel a chemist, Pembrey a physiologist, Hurst a young physician with a physiological bias, rapidly rising into fame, and our present physician. It was just at this time, then, that an overdue event, the wedding of Medicine and Science was taking place, and these were some of the men who were bringing it about.

Like that of many men of science our physician's view was limited to the material plane. I well remember him standing by the bedside of a wretched girl who moaned incessantly, "It's not my guilt, it's his guilt." "Well, well, that's all right then," *muttered the exasperated scientist: so it would have been to his logical mind.* He could only influence his patients psychically by means of which he was himself unconscious. A member of the most favoured class of the most powerful and prosperous country in the world, with a great destiny seemingly before it and a century and a half of solid progress behind it, with liberty both to believe in and to enjoy, with unity and common purpose at home and a great empire abroad, with trust in knowledge and faith in Man's reason, with no sickliness of conscience to weaken, with no psychology to disturb and depress, and not a single fear for the future, he had what we have not, a deep-seated confidence. By means of his powerful character, strong individuality and striking appearance he impressed his confidence on his patients. Add thereto his intellect and attainments, add thereto especially his extreme skill, a mixture of boldness and scientific precision, in the use of drugs, and you will perceive he was a great healer. He was something else of high value besides this: he was a first-rate teacher of Medicine, to the student a godsend, to the older man always an inspiration. Witty he was and easy in humour, broad in the good old English style, but never salacious. A proper record of him will probably never be made, but not because the best stories about him are unprintable. Some of his sallies are worth remembering. "The doses in the Pharmacopœa are made for mugs." Of a timid prescription, "You might just as well spit on it." On hearing that a committee had increased the dose of tincture of belladonna in a mixture from one to two minims, "Reckless devils, aren't they?" Of a severe pneumonia near the crisis, "This is where you've simply got to whizz things in." (The whizzing would consist of oxygen, strychnine, brandy, possibly atropine if the bronchi were moist and possibly adrenalin if the patient were in extremis.) Of drugs in general, "The only way to prescribe is to know the effect you want to produce, the drug that will do it and the dose to produce the effect." Of the streptococcus, "My dear boy, if the streptococcus could not do that, he would not be the lad he is." Jerked out of his urbanity at last by a student who could answer nothing, "Well, what do you think it is? A rush of fluid fæces to the heart?" To another he pointed out that when a person changed from recumbence to the upright, his belly seemed to increase in girth, and he asked him what filled the extra space. "Air," came the astonishing answer. "My God!" he cried. "What a very unpleasant companion you must be!" Of ourselves he said, "The medical profession is the most credulous in the world." He spoke of our very feeble capacity for bargaining and put his finger on the spot. "It is because medical men *will* try to appear as such

philanthropists," he said scornfully—a pose for the sake of which we are going to suffer in the near future, if I mistake not. He believed like Shakespeare in "degree." "They are what they are, because they are what they are," he said of the proletariat; and again, "Some children are born Rolls-Royces, others Ford cars: this is a Ford car." Naturally this sturdy individualist detested the idea of a "socialized" Medicine and in his last utterance to men of Guy's he warned them of what lay in store: in his last letter to the *Gazette* he protested against the intrusion of women students, with some characteristic reference to the spermatozoa of the elephant. He had an excellent idea that Guy's should be an Honours school, but was obstructed with nonsense about the "conjoint men" being the backbone of the profession. (It was probably a matter of fees). This frustration irritated him and led him to regard some of his colleagues with suspicion, so that for a time he withdrew from the councils of the hospital; but when he became senior physician, he proved himself to be a most excellent chairman and leader (or so I have many times been told).

Stories about him must be innumerable, and any one who knew him could add many more; but, it may be asked, did he achieve nothing solid in the world of science? He did: he was the first man to prepare insulin. He actually injected it and got a fall of blood-sugar—and then mysteriously abandoned the whole quest and never even published what he had done. The reason no man knew, and though he was very affable to me, I never tried to pump him on any subject, including this one.

Now, any one who has known Guy's for any length of time, will have recognised this portrait after reading a dozen lines. The man I have been sketching was Arthur Philip Beddard. He was what is called "a Guy's character." Men say that such belong to a race that has well-nigh vanished. "Trachystomus has left us," they cry, "and the days of Boeticus here are numbered. In a little while his voice will be heard no more, and with him will go the last of them." Sure enough there is a deadly uniformity about the life of the day. Demos must go round the garden like Turquin of old, it seems, striking off the head of every poppy that dares project one inch above its fellows. The all-powerful herd dislikes nothing so much as any one that differs from itself, most of all if the difference convey superiority. The interest now is all in the aggregate and not in the individual, all in man the social animal and none in man the human being. There is decay in the belief that each man owes responsibility for his soul, and so decay of respect for the soul itself, which has become little more than an object of psychological quizzing.

How fares it with the happy dead?
For here the man is more and more.

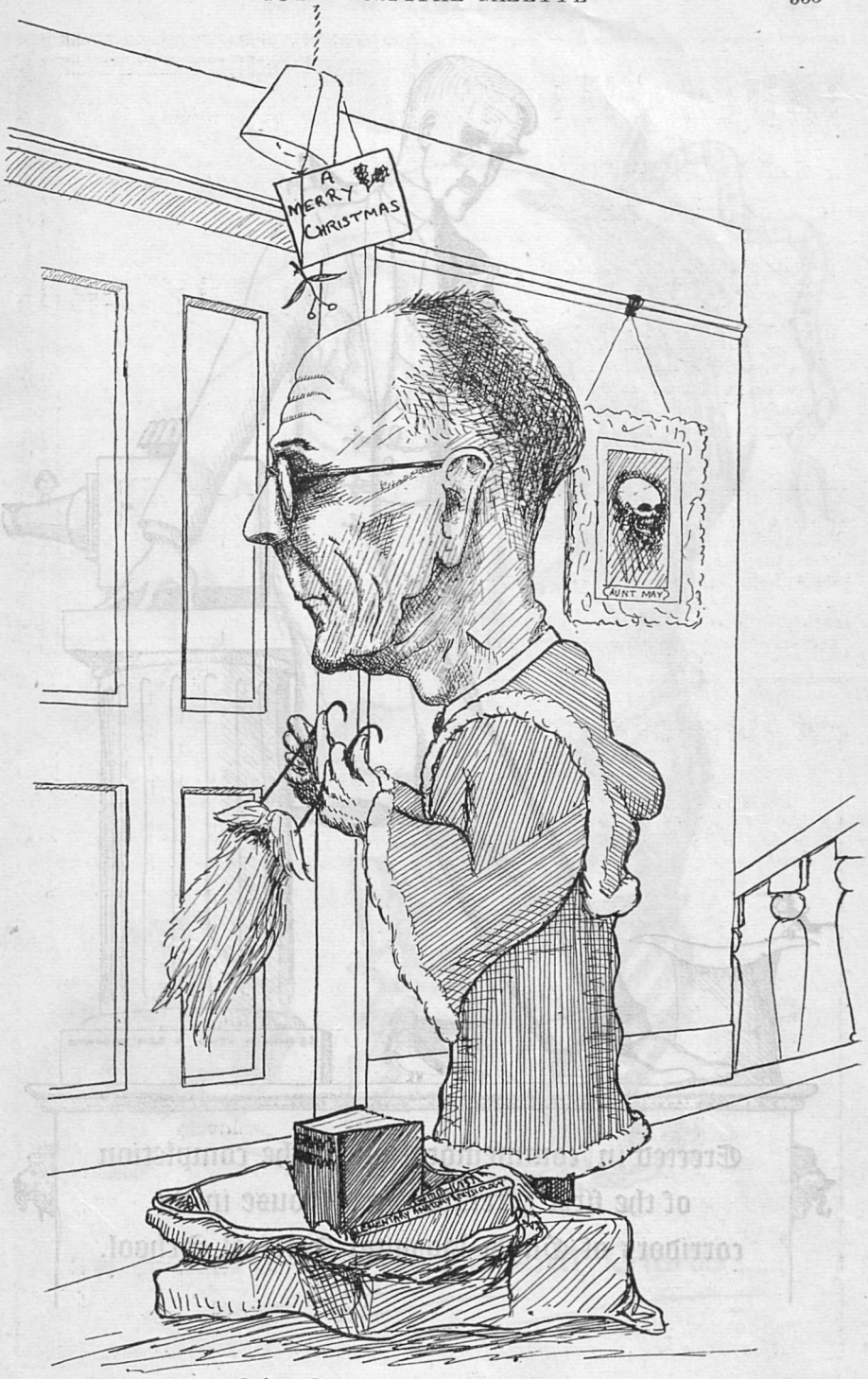
Alas! not! For here the man is less and less. Guy's is still one of the kindest places on earth. No man ever speaks ill of any other man, none traduces his neighbour, or offers petty criticism or sly, sarcastic comment; and if some surly or disagreeable voice comes drifting down the breeze, it may often be guessed whence the wind is blowing, and the appropriate value is set upon the words. But when one dies, a decent service is said above his bones, he is immediately forgotten and his name is never mentioned again. If he retires, he passes out of the front gates after his last round, he is not seen again and his name and fame sink like a stone to the bottom of a pond. Such is the loss of interest in Man as a man. Jacobson, long dead, is still in a way alive: suppose that he and Beddard were men of this age, would they still be "characters" or would all their individuality be "socialized" out of them?

Correspondence

The Hospital and the Future

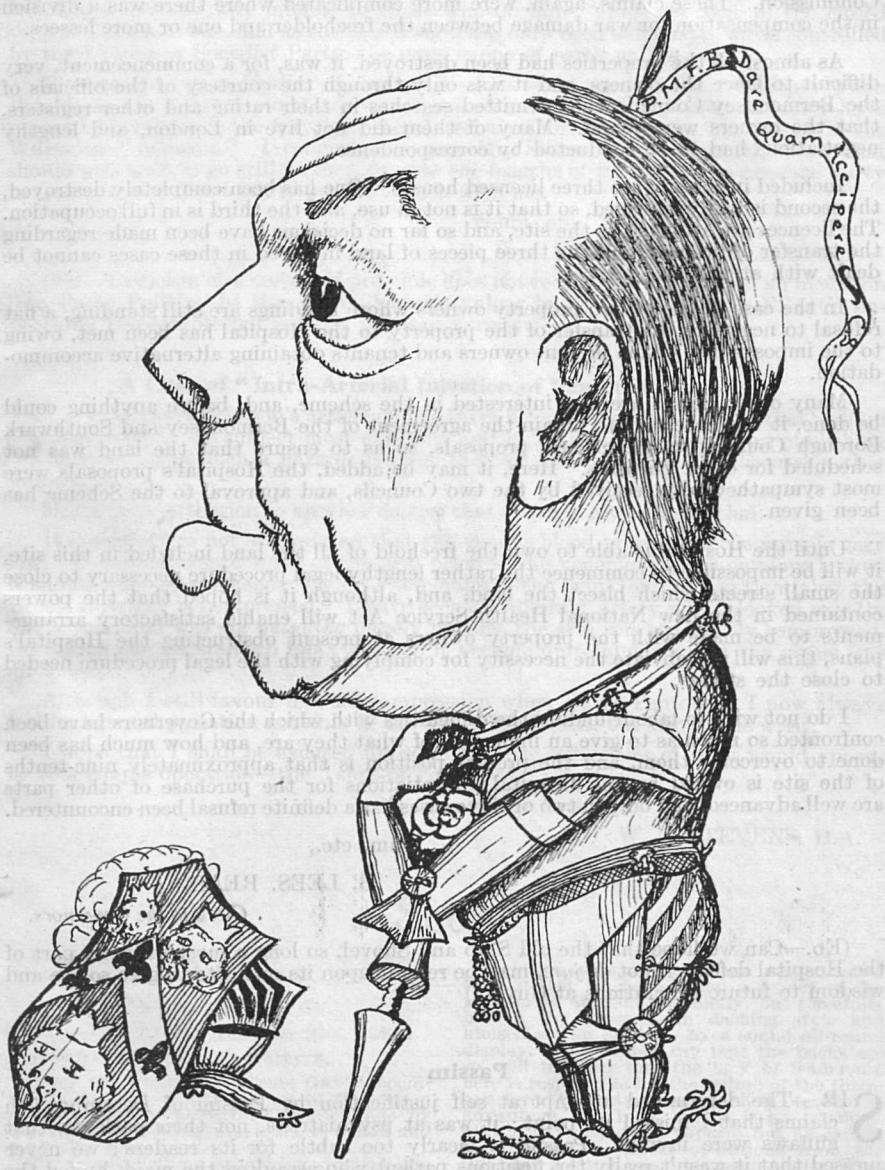
SIR,—There has been some correspondence in your columns recently regarding the work being done to restore the Hospital and plan for the future, and it might be of interest, in this connection, if I explained briefly some of the work that has been entailed in an effort to make available for the extension of the Hospital the site bounded by St. Thomas's Street, Weston Street and Snowfields.

In the first place, some sixty properties were involved, owned by some twenty-five different freeholders. In some cases, the freeholders had let the site on a building lease; the head lessees had, in turn, sub-let at a rack-rental and, again, in one or two cases, there was still a further sub-tenancy. So from one to four persons could be



The Anatomy of Christmas

Erected in commemoration of the completion of the first Prefabricated House in the corridors of Guy's Hospital Medical School.



"Now a word-er two about Giants....."

involved, apart from the Hospital, in the purchase of a single property. Further complications arose where mortgages existed or, alternatively, where the property had been destroyed, and there were claims to be made and settled with the War Damage Commission. These claims, again, were more complicated where there was a division in the compensation for war damage between the freeholder and one or more lessees.

As almost all the properties had been destroyed, it was, for a commencement, very difficult to trace the owners, and it was only through the courtesy of the officials of the Bermondsey Council, who permitted searches in their rating and other registers, that the owners were found. Many of them did not live in London, and lengthy negotiations had to be conducted by correspondence.

Included in the site are three licensed houses. One has been completely destroyed, the second is badly damaged, so that it is not in use, and the third is in full occupation. The licences are attached to the site, and so far no decisions have been made regarding the transfer of licences, and the three pieces of land involved in these cases cannot be dealt with at present.

In the case of one or two property owners whose buildings are still standing, a flat refusal to negotiate the transfer of the property to the Hospital has been met, owing to the impossibility of the present owners and tenants obtaining alternative accommodation.

Many other Bodies are also interested in the scheme, and, before anything could be done, it was necessary to obtain the agreement of the Bermondsey and Southwark Borough Councils to the general proposals, so as to ensure that the land was not scheduled for other purposes. Here, it may be added, the Hospital's proposals were most sympathetically received by the two Councils, and approval to the Scheme has been given.

Until the Hospital is able to own the freehold of all the land included in this site, it will be impossible to commence the rather lengthy legal procedure necessary to close the small streets which bisect the land, and, although it is hoped that the powers contained in the new National Health Service Act will enable satisfactory arrangements to be made with the property owners at present obstructing the Hospital's plans, this will not obviate the necessity for complying with the legal procedure needed to close the streets.

I do not wish to labour unduly the difficulties with which the Governors have been confronted so much as to give an indication of what they are, and how much has been done to overcome them, and the present position is that approximately nine-tenths of the site is owned by the Hospital; negotiations for the purchase of other parts are well advanced, and only in two or three cases has a definite refusal been encountered.

I am, etc.,

B. LEES. READ,

Clerk to the Governors.

(ED.—Can we hope that the old Ship and Shovel, so long a most intimate part of the Hospital defects if not *de jure*, may be rebuilt upon its own site to give solace and wisdom to future generations at Guy's ?)

Passim

SIR,—The determined attempt at self justification by Passim of December 7th claims that I missed its point: it was at psychiatrists, not their patients, that guffaws were invited. Passim is clearly too subtle for its readers: we never guessed that it wasn't really the fictitious patient who assaulted the maid, knifed the guest, or shot the butler (riotous hilarity), but the equally fictitious psychiatrist (ridiculous fellow), who was never mentioned at all !

Such whimsical inconsequence deserves, perhaps, more encouragement than it is likely to receive.

Yours faithfully,

D. STAFFORD-CLARK.

Trade Union in Medicine

SIR,—It is of no significance to the patient whether or not a doctor or a nurse belongs to this or that Trade Union, nor are nurses who belong to "recognised" Trade Unions in any way inferior to those who do not. Thus the issue of the closed shop is a political one, and as the closed shop has only been enforced in areas controlled by the Labour or Socialist Party, the issue is one of party politics.

But ignoring your Passim of August 31st, in which you wrote, "Our profession should, as the Church ought to, stand quite apart from party politics," you have plunged bravely into the fray, and sternly rebuked Dr. Buchan for his actions in the Willesden "incident." I congratulate you, Mr. Editor, and I earnestly hope that should you wish to go still further, even to the lengths of joining a Conservative Party in Guy's, you will not fail to get into touch with me.

Yours, etc.,

R. G. KEABLE-ELLIOTT.

(ED.—Criticism of a matter of principle does not require for its sanction an incursion into Party Politics, be they of Willesden's vulgar brand on Mr. Keable-Elliott's impeccably respectable but equally partisan variety.)

A Case of "Intra-Arterial Injection of Pentothal Sodium"

SIR,—Dr. Brian Johnson's article on the Intra-arterial injection of Pentothal Sodium has covered the subject most expertly, and he is to be commended on publishing the details of such a hazardous case, that all may profit by the discussion that follows.

May I draw attention to another danger that arises in giving Pentothal.

It is sometimes not appreciated that the venous blood pressure in the arms is very low. If manual compression of the arm prior to the venepuncture is employed, then it should only be sufficiently tight as to compress the veins, and not so tight that the Brachial Artery is compressed. I have seen an aberrant artery which looked exactly like a vein, and was *not pulsating* merely because the arm was too tightly compressed. On asking the assistant to relax his grip it became quite obvious that the vessel was an artery.

Although I still favour manual compression when I give Pentothal, I now always feel for arterial pulsation not only in the antecubital fossa, but also at the wrist.

I hope that I shall be excused for adding to the difficulties of what would appear to be a simple operation—the "shot of Pentothal."

Yours faithfully,

W. J. STEVENS, D.A.

Sport

Rugby

GUY'S *v.* COVENTRY.

(*Played at H.O.P., November 30th*, 1946.)

Result: Guy's 11; Coventry 8.

After five successive defeats Guy's accomplished their best performance of the season in defeating the powerful Coventry side by a goal, a penalty goal and a try to a goal and a penalty goal.

This result left us wondering whether the fortunes of the team have taken a successful turn, but I prefer to reserve judgment on account of the fact that Coventry were without three of their best players in Wright, Preece and Greasley. Nevertheless it was a grand performance and the inclusion of G. P. Billingham at centre undoubtedly improved the defensive play of the backs, but I prefer to see him at stand-off half, his correct position.

Another encouraging feature was to know that at last we have found a leader of the pack in B. W. Cole. Quietly, but forcefully he led the forwards in dashing style and himself set an example by a sound all-round display. One cannot say that the backs are so well together and the lack of leadership here is responsible for the failure of the three-quarters to press home their territorial advantage. T. L. T. Lewis is an excellent player and a splendid captain but he cannot be expected to direct operations from the full-back position when his team is attacking, and this responsibility may well be given to D. M. Strathie.

From the start Guy's worried Coventry into many errors and themselves took advantage of the loose ball which enabled them to set up frequent attacks. B. Eksteen was prominent throughout with some sound tackling, but Guy's had to tackle tenaciously to prevent J. Sparkes on the Coventry right wing from crossing our line.

D. Le Clus, who had replaced K. E. Heber on the left wing, scored a neat try twenty-five minutes after the start, and a few minutes later T. L. T. Lewis kicked a penalty goal. Guy's went further ahead when D. N. H. Owen cross-kicked for M. Hatton to follow up and touch down for a good try that T. L. T. Lewis converted. This was the state of the game at half-time, but immediately after the interval H. Smith kicked a penalty goal for Coventry and this seemed to inspire them as they swept forward with determined loose rushes that completely overwhelmed Guy's for a time because nobody would fall on the ball. Late in the game one of these rushes brought Coventry a try, officially awarded to H. Batstone, although at least four Coventry players and some of Guy's were lying in a heap, and H. Smith converted.

Time will tell whether this performance is worth the importance we place on it, but one redeeming feature about the present Guy's XV is that it is capable of tremendous improvement. The standard of play is very high, comparing most favourably with any of our opponents, but they just fail in their combined team-work, a failure to cover up obvious weaknesses, inability to press home their attacks to advantage, and not sufficient use of the wing three-quarters.

Hospital Information, etc.

Notices

Applications are invited for the post of Chief Clinical Assistant and Registrar in the Ear, Nose and Throat Department. Duties to commence on January 8th, 1947. Salary at the rate of £200 per annum, that is £50 per session for four sessions per week.

Applications should be lodged with the Superintendent on or before December 30th.

DEBATING SOCIETY.

Surely no more opportune time could have been chosen by the Debating Society to consider the motion "that this house deplores the attitude of the Executive of the British Medical Association towards the National Health Service Act" than Thursday, 12th December, for it was the very evening that the results of the momentous plebiscite were revealed to the national press. Dr. Clithero being unable to attend as originally arranged, D. R. Welply, the General Secretary of the Medical Practitioners' Union, put the proposition to the House. Defining the attitude of the B.M.A. Council as obstructionist, he explained how he considered that this derived from both political and business motives.

In reply, Dr. R. W. Cockshut, of the B.M.A., demonstrated undeniable gifts of oratory though, like his opponent, he tended to stray from the terms of the motion. He rounded off his declamation by directing a fierce diatribe against the M.P.U. as an organisation.

It was encouraging to notice that the speakers from the floor of the house confined their observations much more closely to the subject, but logical deduction, it must be confessed, was frequently lacking. By far the greater number who had anything to say levelled their criticism at the B.M.A. It therefore appeared somewhat paradoxical when, upon a vote being taken, Dr. Whillis—a chairman of worthy impartiality, was able to declare the motion lost by eleven to twenty-three.

T. K. BOENHEIM,
R. GOULDING,
Joint Honorary Secretaries.

ASTLEY COOPER STUDENTSHIP.

This Studentship, tenable at Guy's Hospital Medical School, has become vacant.

The Student who is called the "Astley Cooper Assistant to the Curator of the Gordon Museum" will be elected for a period of three years.

Particulars regarding the Studentship can be obtained from the SECRETARY to the Astley Cooper Trustees, Medical School Office, Guy's Hospital, S.E.1, to whom applications for the post should be addressed on or before 1st January, 1947.

Appointments

H. F. Lunn, F.R.C.S., has been appointed Anatomical Curator, and Sir Halley Stewart Research Fellow of the Royal College of Surgeons.

Major Min Sein, M.B., M.R.C.P., has been appointed Senior Physician, General Hospital, and Professor of Medicine, Rangoon University, also Medical Superintendent.

C. H. Blockley, L.D.S., R.C.S.Eng., has been appointed Honorary Assistant Dental Surgeon to the Kent and Sussex Hospital, Tunbridge Wells.

The Services

AWARDS.

U.S.A. Award.

H. H. Kenshole, D.S.O. (T.D.), has been awarded Bronze Star Medal.

Territorial Decoration.

Major K. W. N. Palmer, R.A.M.C., has been awarded the Efficiency Decoration of the Territorial Army.

Marriages

MACQUEEN—CULVER.—On Friday, November 29th, 1946, Ian James MacQueen, to Dorothy Maud Culver.

Births

LUNN.—On November 25th, 1946, at Nuffield House, to Agnes Rosalind, wife of H. Fletcher Lunn— a son.

MOYERS.—On December 3rd, 1946, at Braeside Nursing Home, Southampton, to Margaret (née Briggs), wife of H. W. Moyers—a daughter.

HOPKINS.—On 3rd December, 1946, at Ismailia, Egypt, to June (née Best), wife of Lt. Philip Hopkins, R.A.M.C.—a daughter.

SIRETT.—On December 8th, 1946, to Vanora (née Gellibrand) and Thomas Sirett, of Rockmill House, Stroud, Gloucestershire—a son (bother for Jean Mary).

Deaths

SHEARE.—On November 16th, 1946, Sydney David Sheare, M.R.C.S., L.R.C.P., of 146, Harley Street, W.1.

EDS. { R.T.H. D.H.F.